Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23b per doc 9871 9-26-07 vt.
State of Maryland? Department of Health and Mental Hygiene amend item 7 per fh g871 9-20 all wate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:36P [™] Lear Myers Mack September 8, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton, Maryland Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex BishopVille, 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 □ X 90 579-30-3153 July 28, 1917 S. Carolina **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ∑Yes 2 No N/A N/A Director Washington, DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 230 35th Street NE 20019 United States Funeral Apt #2 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Internatively in the important: if tem 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Laundry Presser Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julius Myers Bina Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5202 Hayes Street NE, Washington, DC Marcus Mack / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Purial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 9/21/2007 Washington, DC 22. Name and Address of Facility
Pope Funeral Home, 2617 Pennsylvania Ave, SE, 21. Signature of Tyneral Service Ligersee Laru comm Washington, DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Myocardial Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending philor use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not respiting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2⊡No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P0062200 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Amit Suri, MD 31. Date filed (Month, Day, Year) 7503 Surratts Road, Clinton, MD 20735 State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** صدر مديدة Deborah Bishop Phillips /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 162 Danford Drive E1kton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 M 2 X F New York 18. 1950 **Director** 213-58-0841 56 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 X Yes 2 □ No Directo Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 251 West Main Street 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: δ 3 ☐ Widowed 4 👿 Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Customer Service Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ross O. Bishop Shirley Mae Collumbell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva M. Ferretta/Daughter FPO AE 09636 PSC 836 Box 515, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Gilpin Manor September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 25, 2007 Elkton, Maryland Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 ma 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** elan years /Medical Due to (or as a managuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of) physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by pe 4 Unknown 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🔼 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) idge St., Elkton, M. 0 7 /3/ 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 6 2007 Registrar

Division or Vital Records, P.O. Box 68760,2

			1 - For State Registrar	State of Maryland		irtment of He <i>tificate of E</i>			200°	7 31003
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Van	3. Time of Death
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	Examin	ıer	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or			4c. County of De	eath
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	Funeral Director			M 201 72	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG 20,	Year) 1935 Pe	Country)
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	with ti	<u>a</u>	10e. Street and Number		005	10f. Zip Code		10	og. Citizen of What	•
	eath	erai	1000 Franklin Aven	ue, Apartment 12. Was Decedent Ever in U.S		21221	enanic Origin? (Sn	acdy Vas or No-	United	States merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Items 23e or 28e-f ehow early injury or other traumatic event. The Medical Examinar must be notified at another.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Amed Forces? 1 Yes 2 W No If Yes, Give A Year or Dates:	li li	Vas Decedent of His f Yes, specify Cubar □ Yes 21 No	Specify:	Rican, etc.)	Black, W	
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8760, ~	Physician physician and Medical Examiner transit stip private the paragraph of the paragrap	dicai Examiner	23a. Part Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leaving to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	rence of):					Interval Batween Onset and Death
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			For State Registrar	State of	of Marylar	-	artment rtificate			ınd Men		ene g. No. 2	007	31004
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)36 Irs after death	Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mal 3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed F rried 1 Yes	2 ⅓N o ive		Was Deceder	/ Cuban	panic Orio	gin? (Specify , Puerto Rica	Yes or No-		ice - Americ ack, White,	ean Indian, etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For the Registrer and 19a, FH, TCHD, 9/24/07, pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Betty Mae Ernestine Perry 2007 /Medical 09 1:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 713 High Street Dorch ester

9. Birthplace (State or Foreign
Country) Cambridge
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 07-12-1936 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 200 F Director 218-30-1425 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 PYes 2 □ No Director Md. Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 713 High Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Þ 3 ☐ Widowed 4 ☐ Divorced Black 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundle Co. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Officer Juvenile Services 4 Parole & Probation es 1 and 2 should be filed to the solution of Health and Mental Hygie of Health and Mental Hygie of Her I sewent, II other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert James Perry Mary Catherine Pinder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 4 3 19a. Informant's Name/Relationship (Type, Print) perrit. Pages 1 and 2 s Department of Health ar Important: if item 27 Is any injury or other trau Patsy Pasty Collins 7037 Williamburg, Church Rd. Hurlock, Md. Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel Church Cem 09-15-07 Cambridge, Md. 22. Name and Address of Facility Bennie Smith funeral Home 21. Signature of Funeral Service Licensee 524 Race St., Cambridge, Maryland 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) **Physician** minute /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as Examiner by the attending physician and tached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed I det 23e. Did tobac e contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 L es 2 □ No 3 ☐ Probably 4 ☐Unknown Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed certificate 1 ☐ Yes 2 ☐ No 210 NO Division of Vital ector, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 P sidence 6 Other (Specify) ဥ ₽ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attanding 1 Dilatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determin 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

4 corrected

State Registrar

DHMH 17 Rev 1/2001

300 Dorchester Ave., Cambridge, Md. 21613

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

D. Moore, M.D.

			For State of Maryl State Registrar		irtment of Health ar <i>tificate of Death</i>	_	giene Reg. No.2 N N 7	31006
D			Decedent's Name (First, Middle, Last)			2. Date of De Month		3. Time of Death
	Physicia /Medic		Margaret Anna Payne			09	05 Year 05 2007 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number) Brighton Gardens Nursing Home		4b. City, Town, or Location of Bethesda	Death	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 87 Security Number 1 M 2 1 F 87	yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Bir (Month Date)	th year) 9. Bir 1920 Mar	thplace (State or Foreign ountry) yland
	pus M		Usual Residence of Decedent 10a. State 10b. County 10c	c. City. Town or Lo	cation			10d. Inside City Limits
	Maryla f sho	tor		coma Par	k			1 XYes 2 No
	th the or 28a e notif	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	ath wil	ral	223 Manor Circle		20912		U.S.A.	vices ledies
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 Nowled Year or Dates:	1	Was Decedent of Hispanic Origi f Yes, specity Cuban, Mexican, i ☐ Yes ※ No Specify:	n? (Specify Yes of No Puerto Rican, etc.)	Black, Whi	
21215-0036	- 3 0	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	dent's Usual Occupation kind of work done during most of DO NOT use retired)	of working	16b. Kind of Business	/Industry
	filed w Hygie other ti	S	-12-	Home	Maker 18. Mother	s Name (First, Middle	Own Home , Maiden Surname)	
lan	should be filed withir nd Mental Hygiene. marked other than umatic event, the Me	To Be	Otto H. Hoffman		Marie	e M. Lathr	oum	
Maryland	nd 2 shou alth and M 27 is mai r traumai		19a. Informant's Name/Relationship (Type. Print) Bernadette M. Hoffman/daughte		ng Address (Street and Number Bayfront Road			· ·
Baltimore,	Pages 1 an nent of Heal ant: If item 2 ury or other		1 Nouriel 2 Compation 2 Demoval from State	cob. Place of Dispo cemetery, crer ate of H	matory or other place)	Date 9/11/2007	20c. Location - City o Silver Spri	Town, State
Baltir	permit. F Departme Importar any Injur		21. Signature of Funeral Service License		2. Name and Address of Facility		E. Evans Fu ie, Marvlan	
			23a. Part1. Enter the disease, or complications that cau ed the shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	rerosd	intre Hea	rot Olis	ease	Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a co.	nsequence of):	Ka.			
		ner	Ecquentiary liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	talkano ott.	">			
68760,	e be ex sician e burial	dical E	d Corx	restre	Heart fo	whene		
					U			
O. Box	he death certifics the attending ph ched for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcone pt pt 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of do Month	elivery Day Year
ds, P.O.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in Part I.		tobacco use contribute Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
Records,	e la has	Completed				24a. Was auto perf 1 Yes	s an 24b. Were a prior to death?	
ita	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			of Death Check onl	one	
or Vital	sir ldir	ဍ		2 ER/Outpatier	nt 3 DOA Other: Nur		sidence 6 Other (Sp	ecify)
	nding I th. : After s funer	tion:	1 Matural 5 Pending (Month, Day Ye		f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ N		now injury occurred	
Division	or Atter after deal Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - building, etc. ⟨S	At home, farm, str Specify)	reet, factory, office	28f. Location City or To	(Street and Number or I own, State)	Rural Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of medical Examiner: On the basis of examiner and manner stated.	amination and/or ir				
	To th within To th comp	Me	29b. Signature and title disertine?		29c. License number		29d. Date signed (Mo	
	- Ch		· // Veca	-	D53691		September	/, 200/
	10 us.			Democracy	y Blvd., Bethes	sda, Maryla	and 20817	
	Sta Regist		31. Date filed (Month, Day, Yegf) 32. Bgistrar's SEP 1 1 2007	Signature	Carl .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9/6/2007 **Physician** Kathleen Mary Pendleton 2:30 m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 855 Cork Elm Ct. Severn Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9/1/1956 9. Birthplace (State or Foreign 5. Social Security Number 065–48–9508 **Funeral** Months Days Hours Min. 1 M 200 51 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD Anne Arundel Severn 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 Cork Elm Ct. 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Asst. National Response Cen. 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Murphy Diana Mary Hanlon P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Pendleton Spouse 855 Cork Elm Ct. Severn, MD 21144 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Hipportant: If ite any Injury or ot once. 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 9/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease shock, or heart failure. I . or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer Months disease or condition resulting in death) /Medical Due to (or as a o nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner as the burial-trans Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မှ funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending

The law requires that the death certificate be executed physician attending p for use as ed by the a detached f been signed b page 2 s certificate Hospital or Attending Physician: director After this

r death.

after death

within 24 hours a

To the Funeral [

þ

filled in

completely

Division or Vital Records, P.O. Box 68760,

Maryland

the

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

f Health tem 27 i

"natural"

3altimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

array M.D

D39505

September 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Br. Glen Burnie,

State Registrar 31. Date filed (Month, I P 1 1 2007

2 Accident

4 Homicide

3 Suicide

			State of Maryland / Department of Health and Mental Hygiene 007 31008 Certificate of Death State of Maryland / Department of Health and Mental Hygiene 007 31008
	Physici		1. Decedent's Name (First, Middle, Last) Everett Emerson PETERS, Sr. 2. Date of Death Month Day Yeer September 9 2007 0959&
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 1/12 M 2 F 78
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	the Mar 28a-f sh	Director	Maryland Anne Arundel Annapolis 1 □ Yes 2 □ No
	th with 23a or		885 Marengo Street 21401 USA
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itema 23s or 28s-f show imatic event, the Widfeld Eximitations and the additional features.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 No If Yes, Sive 1951-5 1 Never Married 2 N
12-0	"nature	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Occupation 16b. Kind of Business/Industry
Maryland 21215-0036	filed within Hyglene. other than ent, Ite We	Completed	12th 6 yrs. Teacher Teacher of Education
land	id be filk ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Lester Gerard Peters 18. Mother's Name (First, Middle, Maiden Sumame) Savada Blake
lary	2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
timore, N	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic		Yevola S. Peters (Wife) 885 Marengo Street Annapolis Md. 21401 20a. Method of Disposition 1 Burial 2 Micromation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
E I	permit. Pages Department of I Important: If Its any injury or o		`4 □Donation 5 □Other (Specify) Metro Crematory 9-11-07 Baltimore, Md.
Ba	Dep Imp		Javry G. Agese Moo483 Wm. Reese & Sons Mortuary, P.A. 21401
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause neach line. Immediate Cause (Final disease or condition resulting in death) a
	Examiner		Due to (or as a consequence 1/2: Sequentially list conditions, b. YEGNS
20,	certificate be executed title by the size and the burial-transit	I Examiner	"any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):
68760	ate hy: the	ledical	d
O. Box	death e atter od for u	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Year Year
ecords, P.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 1 10 16 2 1 No 3 Probably 4 Unknown
T,	The ate has page	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Ves 2 Sub 1 Ves 2 Sub 1 Ves 2 Sub 1
Vital	y sician : Th	o Be	25. Was case referred to medical examiner? 1 Yes 2 No
n of	ding Phys h. After this funeral di	-	1 Yes 2 No
Division	ten deat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
-	o the Hospital or Al thin 24 hours after of the Funeral Direct mpletely filled in by	edical Co	29a. Certifier (Check only one) 11. Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2/1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within 2 To the Complet	3	29b. Signature and the di certifier 29c. License number 29d. Date signed (Month, Day, Year)
(PX B	۲	30. Name and address of person the completed cause of depth (Item 23a) (Type, Print)
	Sta Registr		31. Date filed (Month Day, Year) 2007 31 Pegistrar's Signature of the SEP 1 1 2007

			State 1 - State Registral/MEND#29d,perMD,9/12/	of Maryland 07,DPS,MbCo		artment of He <i>tificate of D</i>			eneg () () / g. No.	31009
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio	_	Florence Irene Price	<u> </u>				Septembe	er 8, 200	7 9:20 a M
-	Examir	er	4a. Facility Name (If not institution, give street and			4b. City, Town, or L	ocation of Death		4c. County of De	ath
1.		A	Bedford Court Nursing	1			er Spring			ntgomery
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ 1	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 10	^{9. B} , 1916 C	irthplace (State or Foreign Country) anada
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	ŗo	Marria Mantaganana		c	: 7 C	:			1 ☐ Yes 2 🖾 No
	28a	rec	Maryland Montgomery 10e. Street and Number			ilver Spri	ing	10	g. Citizen of What 0	Country?
	h with	D	419 Hillmoor Drive			20901		Į	JSA	
	r deat	ner	Armed	ecedent Ever in U.S. Forces?	13. \	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	nerican Indian, nite, etc.
036	ours afte ral', or i Examir	by Fe	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Year	es 2∏No Give XX or Dates:			Specify:		Specify: W	hite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23e or 28a-f show amounts in your or other traumatic event, the Midfield Examines must be notified at anote.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	(Give	lent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng 1	6b. Kind of Busines	s/Industry
	filed w Hygien other th		17. Felharia Nama (First Middle Loca)		Home	maker	10. Mark - d- Mar-	(Fine 1474)	Own Ho	me
anc	d be find the office of the of	Be	17. Father's Name (First, Middle, Last) Edwin E. Ordidge			1	18. Mother's Name Margare	et Anna 1		
Maryland	should ind Men inarke	유	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street an				Zin Code)
Ma	and 2 s ealth an n 27 is ser trau		Eileen E. Wood/Daughte	r		4 1 9 Hillmo				
<u>6</u>	f Healitem		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of		ate 2	Oc. Location - City of	
E	Pages nent of 1 int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State	-	natory or other place) eaven Ceme	eterv	12, S:	ilver Spr	ing, Maryland
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Liceusee	00 -	1000	Name and Address	Collins I	Funeral I		20 00003
	100		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death.						ng, MD 20901 Approximate
	Physician		Immediate Cause (Final disease or condition			5 DISE				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	to (or as a conseque	nce of):					
	-	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conseque	nce of):					
	aath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o	an an Irial-tr	Exa	resulting in death) Last Due	to (or as a conseque	nce of):					
68760,	ate be nysici he bu	edical	d							
	e as t	Med	IF FEMALE:							
Вох	eath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 morths?	outcome of pregnance re birth 2 Petal d	eath 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
o.	the de	Physician/M	1 Yes 2 No 4 Pr	egnant at time of dea nknown	th 5∟	Other (specify)				-7
σ.	that the de led by the detached	y Ph	Part II. Other significant conditions contributing t			nderlying cause given	in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by	DIABETER M	ELLITUR	<u> </u>			1 ☐ Yes	s 21 2 № 3 🗆 1	Probably 4 Unknown
တ္တ	aw requis been 2 should	plet						24a. Was an	24b. Were	autopsy findings available
	sician: The law certificate has b irector, page 2 s	Completed						autopsy perform 1 Yes 2		o completion of cause of
ita	ertifica ctor,	Be (25. Was case referred to medical examiner?				26. Place of Death			
of Vital	hysic his ce	Jo	1 ☐ Yes 2 ☐ Hospital: 1		7/Outpatien		4 Dursing Ho		nce 6 Other (Sp	pecify)
ion	nding P ath. r: After t e funera	Certification;	27. Manner of De th 28a. Da 1 Natural 5 Pending (A Accident investigation	ate of Injury 2 fonth, Day Year)	8b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	es 2 🗆 No	28d. Describe hov	w injury occurred	
Division	or Atte	ertific		ace of Injury - At hom uilding, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only 1 Certifying Physician: To 2 Medical Examiner: On the	e basis of examinatio	edge, death n and/or inv	occurred at the time restigation, in my opin	, date and place,	and due to the car	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	thin 2 the mplet	Medical	one) and m 29b. Signature and title of certifier	nanner stated.		29c. License			d. Date signed (Mo	
7	3		4 OOL	w					9/8	9/8/2007
	_		30. Name and address of person who completed of	ause of death (Item 2		Print)	5054: WILL Tak	0.0	0/0001	mp,
	Sta	te	31. Date filed (Month, Day, Year) 33	000011-		Frenuc	191	ung for	γų "9)	2041 -
	Registr		SEP 1 2 2007	Marie !	X A	aste)				

State Registrar 31. Date filed (Month, Day, Year) SEP 1 2 2007

Jakies Rost MD

address of person who completed cause of death (Item 23a) (Type, Print) s Rost MD 9901 Medical Center Dr. Rockville, Md 20855 egistrar's Signature

Months

10f. Zip Code

1 ☐ Yes 2 K No

7. Age (In yrs. last birthday)

77

10c. City, Town or Location

Silver Spring

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

579-34-9563

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

Adele Z. Penn

1 □ M 2 🖵 F

1121 University Blvd., West, # 1016

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes 2 X No Yes, Give

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

Maryland Montgomery

1 Never Married 2 Married

4b. City, Town, or Location of Death

Silver Spring

If Under 1 Year | If Under 24 Hrs.

Hours

Specify.

Days

20902

Reg. No 2007

4c. County of Death

Montgomery

Day September 10, 2007

2. Date of Death

7:58 A.M.

9. Birthplace (State or Foreign

Physician /Medical Examiner

Funeral

Directo

Funeral

Director iral", or Items 23a or 28a-f shov Examiner must be notified at the Medical

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23 Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Administrative Associate 17. Father's Name (First, Middle, Last) Be Samuel Zaritsky 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai Arthur A. Penn - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) IX Burlat 2 □Cre 3 KRemoval from State KING DAVID MEML GDNS 09/12/2007 5 ☐ Other (Specify) **∦** Donation Funeral Service Licensee Sign Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Immediate Cause (Final **Physician** CARDIAC FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTROINTESTINAL BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed NON HODGKIN'S LYMPHOMA burial-trai Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🛣 No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknow signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ATRIAL FIBRILLATION funeral director, page 2 should Completed DEGENERATIVE ARTHRITIS Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident after death filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number D35996 nde 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA M. BURRELL, MD 31. Date filed (Monts Ear State 2007

8. Date of Birth (Month, Day, 12, Wash. D.C. Aug. 1930 10d. Inside City Limits 1 ☐Yes 2 ☐ No 10g. Citizen of What Country? U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry **Insurance Agency** 18. Mother's Name (First, Middle, Maiden Surname) Esther Fishman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 University Blvd., W # 1016, Silver Spring Md. Date 20c. Location - City or Town, Stat

FALLS CHURCH, VIRGINIA

DANZANSKY-GOLDBERG MEMORIAL CHAPELS 20852

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death

1 DAY

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 3 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

1 DAY

5 YEARS

28d. Describe how injury occurred

24a. Was an

autopsy performed? 1☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) SEPTEMBER 10, 2007

2730 UNIVERSITY BLVD #400, WHEATON, MARYLAND 20902

Registrar



			For State Registrar	State of M	Maryland		artmen <i>tificat</i> e			and Me	_	giene, Reg. Nd.	2007	310	12
4	Physici		1. Decedent's Name (First, Midd Jane Remente								2. Date of Dea	Dąy	, aďď	3. Time of De	
2	/Medic Examir		4a. Facility Name (If not institution Memorial	on, give street and number			4b. City,	Town, or	Location of			4c.	County of Death	h	
	Funeral Director		5. Social Security Number 186-09-8664	6. Sex 7. A	nge (In yrs. Ia 88	ast birthday) Yrs.	If Under Months	1 Year Days	II Under Hours		B. Date of Birt 4 Month, Da	h 979	9. Birti Phi	hplace (State or Fo Unitry) Tadelph	ia ia
	land DW		Usual Residence of Decedent 10a. State 10b. Count		10c. City	, Town or Lo	cation							Pa 10d. Inside City L	imits
	Be-f eh	ctor	Md Talb	ot	Cl	aibor	ne							1 ☐ Yes 2{	
	3a or 2	i Dire	10e. Street and Number 10442 Claibo	rne Rd.			10f. Zip	Code 162	4			10g. Citi:	zen of What Co SA	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "neturel", or items 23a or 28e-f show importants if Item 27 is marked other than "neturel", or items 23a or 28e-f show all high receiving or other traumatic event, the Musical Examinar musice motified at ances.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Maa 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	? No		Vas Deced f Yes, spec		ispanic Ori n, Mexican Specity:	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)		14. Race - Ame Black, White Specif Whi	e, etc.	
Maryland 21215-0036	within 72 hc ene. than "netur he Madical	ompieted	(Specify only higher Elementary/Secondary (0-12)		r 5+)	life. L	lent's Usua kind of woi DO NOT us reta	rk done d se retired	turina mosi	t of working	g	16b. Kii	nd of Business/ Scott	Resear	ch
nd 2	be filed ntal Hygie od other	Be	12 years 17. Father's Name (First, Middle								(First, Middle,		Sumame)		
ıryla	should and Meni marke umatic	ှင	Robert Rem 19a, Informant's Name/Relation			19b. Mailin	g Address	(Street a			Gille		r Town, State, 2	Zip Code)	
	and 2 lealth a m 27 le		Richard Rhin	e (son)	ant B	232	53 M	apl	e Ha	ll Ro	d. Cla	aibc	orne, M	Md. 216	24
20a. Method of Disposition Capitol Crema Capitol Crema											2007	Dov	cation - City or 'er, De	∍.	
Bail	permit. Departn Imports eny inju		21. Signature of Funeral Service	11 4	lu								Home		
	Physician /Medical		23a. Part1. Enter the disease, c shock, or heart lailure. Lis Immediate Cause (Final disease or condition resulting in death)	r complications that cause t only one cause on each	ed the dean line.	Do not ente	er the mod	BOX e of dyin	g, such as	cardiac or	Mich respiratory ai	naei rrest,	s, Md	Approximate Interval Between Onset and Dea	en ath
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Coral	is a consequisa a consequisa cons	sequence of):								years	
8760,	icate be executed physicien and s the burial-transit	ical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a consequ	ence of):									
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pr					2	23d. Date of del Month	ivery Day Yea	ır
	w requires that sbeen signed b should be deta	þ	Part II. Other significant condit	ions contributing to death	but not resu	Iting in the ur	nderlying c	ause give	en in Part I.	,		obacco u Yes 2[the cause of deat	
Division of Vital Records,	The law re ate has bee page 2 sho	Completed	Din	bebes							24a. Was autor perfo 1 Yes		24b. Were au prior to death?	itopsy lindings ava completion of caus	ulable se ol
Vita	Physician: r this certifica ral director, i	o Be	25. Was case reterred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	al Hospital: 1 ☐ Inpat	tions 2	ER/Outpatien	t 3 DC	Othe	200		(Check only o		S □Other (Spec		
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	 -	27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of In	jury	28b. Time of Injury		Bc. Injun Work		28	e 5 Nescribe I			city)	
Divis	ital or Atters as after de al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory building, etc. (Specify)							28	3f. Location (S City or Tox			ıral Route Number	r,
	To the Hospital within 24 hours to To the Funeral completely filled	Medical	29a. Certifier 1 Certifyi (Check only 2 Medica	ing Physician: To the bes I Examiner: On the basis and manners	of examinati	wledge, death ion and/or inv	occurred vestigation,	at the tim in my o	ne, date an pinion, dea	d place, ar th occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
)	To the within To the Complex	Me	29b. Signature and title of certifit	· P	MI		290	License	number	0		29d. Dat	e signed (Monti	h, Dey, Year)	
	6			n who completed cause of					_						
1	Sta Registr		Robert Sar 31. Date filed (Month, Day, Year SEP	16 2007 32. sgis	Strar's Signat	dlewi	Ta A	ve.	, Ea	ston	, Md.	_21.	501		

Jane Rhine

24 hours a npletely within 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SP 1 31. Date filed (Month, Day, Year)

SEP 1 1 2007

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State

747

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Registra

200

30. Name and address of person who completed cause of death (Item 23a)

Chief Medical Examiner

strar's Signature

David Fowler M.D.

			1 - For State Registrar	State of M	aryland / De <i>C</i>	partmen ertificate	t of Health a e of Death	and Me		en 2 007	31015
			1. Decedent's Name (First, Middle, L	ast)				2	2. Date of Death		3. Time of Death
	Physici /Medio		Elizabeth	Singleta	ary			s	Month Sept. 1	Day Year 16, 2007	8:20A M
	Examir		4a. Facility Name (If not institution, ga	ive street and number)		4b. City,	Town, or Location	of Death		4c. County of De	ath
	Funeral		Fort Washingt 5. Social Security Number 6.	Sex 7. Ag	al e (In yrs. last birthda	y) If Under		24 Hrs. I A	Date of Rinth	Prince 9. B	inthplace (State or Foreign
	Director		577-34-8659	1□M 2 ∑ F	91 Yrs.	Months	Days Hours	Min.	(Month, Day,	1915	SC
	pu >		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Lacation					10d. toside City Limits
	aryla shov	٦									1⊠ Yes 2 □ No
	M Pe M	ecto	Md. PG	-	Ox	on Hi				0.00	
	with the	급	10 3021 300			10f. Zip				g. Citizen of What (
	s 23	erai	5416 Virginia	12. Was Decedent	Everin II S 1		20745	inin? (Speci		United S	
98	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or tlems 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2127 If Yes, Give		tf Yes, spec	tent of Hispanic Ori cify Cuban, Mexicar 212 No Specify:		can, etc.)	Black, Wh	ite, etc.
21215-0036	hour:		3 XWidowed 4 □ Divorced	Year or Dates:	1 10: 5		10		1.	В	Lack
쟌	n 72 n nat	Completed	15. Decedent's l (Specify only highest g	rade completed)	(G.	cedent's Usua ive kind of wor e. DO NOT us	rk done durina mos	st of working	, '	6b. Kind of Busines	s/Industry
12	within ene. than "	u d	Elementary/Secondary (0-12)	College (1-4or	5+)	Dome				Privat	-0
	Hygi Hygi other		17. Father's Name (First, Middle, Las	st)	1	DOME		er's Name (First, Middle, M	aiden Sumame)	_e
Maryland	should be nd Mental marked c	To Be	Unknown				Eva	Bo	ostic		
7	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address				City or Town, State,	Zip Code)
ž	od 2 1th a 27 is		Oleather Durha	m/daught	er 541	6 Vir	ginia C	ourt	2074	-	
ē,	Head Head Item		20a. Method of Disposition		20b. Place of Dis	sposition (Nan erematory or of	I Mary	Tand	2074	0c. Location - City of	or Town, State
Ĕ			1 ⊈Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		Ft. Lin			/22/	07 B	rentwoo	d, Md
Baltimore,	permit. Page Department Importent: It any injury o		21. Signature of Funeral Service Lice	ensee				<u> </u>		Edwards	
0	90E 2 9		Januce	Edwa	de:	3910 5	Silver E	Hill	Rd. S	uitland	,Md.20746
	Pnysician	3 1	23a. Part I Inter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that cause ly one cause on each li	the death. Do not ne.	enter the mod	e of dying, such as	cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	Ē	vooring in county bust	Due to (or as	a consequence of):			0			U
87	physi the t	dlcal		d							
Вох 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pr	egnancy			23d. Date of d	elivery Day Year
P.O.	it the deg by the a tached fo	hysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	time of death	5 Other (sp	ecify)			Month	Day Toal
ds, F	ires tha signed I be det	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the	e underlying ca	ause given in Part I	l.	23e. Did toba	OV	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	w require been si should	Completed									
Rec		ם							24a. Was an autopsy perform	ed? 245. Were prior to death?	autopsy findings available o completion of cause of
<u>=</u>	n: Th ficate ficate		25 114						1 Yes 2	ANO 1 TY	s 2 No
₹	sicles	Be	25. Was case referred to medical examiner?	Hospital:			Othor		Check only one		
o	Phys r this ral di	5	1 Yes 2 No 27. Manner of Death	1 Elimpatio			INC			nce 6 Other (Sp winjury occurred	pecify)
0	ding h. Afte fune	ţ	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Year) Injur	у	8c. Injury at Work? 1 ☐ Yes 2 ☐			,,	
isi/	Attending Physicien: r death. sctor: After this certifici	fica	3 ☐ Suicide 6 ☐ Could not	be as Blace of In	ury - At home, farm,		r, office	28			Rural Route Number,
á	el or A efter I Direc d in by	Certification;	4 Homicide		c. (Specify)				City or Town,	State)	
	To the Hospitel or Attending Physicien: The law within 24 horus effected adds. To the Funeral Director, Affer this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Sertifying F (Check only one)	Physicien: To the best eminer: On the basis of and manner st	f examination and/or	eath occurred a investigation,	at the time, date an , in my opinion, dea	nd place, an ath occurred	d due to the ca I at the time, da	use(s) and manner to the and place, and di	as stated. ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1 1 1 1			. License number		29	d. Date signed (Mo	nth, Day, Year)
			A.M.S	7/2/	L P I N	Cim	460	04	6	7-16	2007
	,		30. Name and address of person wh	o completed cause of	leath (Item 23a) (Typ	De, Print)				1	
	3		Mirza Alikhani	M D	11711 Ti		ton Pd	Ft	. Wash	ington	Md.20744
	Sta		31. Date filed (Month, Day, Year)	A Registr	ars Signature 38	11193	con Au.	7			
	Registi	ar	SEP 2 6 20	JUI Filescan	S. A.	-					an all the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2007 HELEN STOKES 9:10 M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNINGRESITY 1400 CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗹 F Months Days Hours Min 220-26-3309 Director 10/20 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director MD Kent 1 NYes 2 □ No Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21447 Sharp St. 21661 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No Specify White ģ 3 XWidowed 4 ☐ Divorced "natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Leon Glenn Mary Susanna Kellev မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kevin Stokes (son) 22-24 Kelly Park Rd. Item 27 other t Rock Hall, MD. 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any injury or o 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cem. 9/24/07| Rock_Hall, MD. 21. Signature of F eral Service Licens 22. Name and Address of Facility Gal 118 Home of Stephen L Schaech St. Galena, MD. 21635 ena F uneral Cross M00510 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCHEMIC 100W61 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician the burial P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No Division or Vital Hospital or AttendIng Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check only one) မှ 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely (Check only within 24 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P21050 TBOOB 30 Hame and address of person who completed cause of death (Item 23a) (Type, Print) South Bultimore, NO 2120 HABOOB 0

DHMH 17 Rev 1/200

State Registrar

MOUNT

31. Date filed (Month, Day, Year)

breene

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician Physician Ω /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center University of V 5. Social Security Number Bultimore Baltimore Co. 8. Date of Birth Apr. 17, 1979 9. Birthplace (State or Foreign Country)
Wash.D.C. . Age (In yrs, last birthday) If Under 1 Year | If Under **Funeral** Months Days Min. **X** M 2 □ F Hours 579-98-1426 28 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State r 28a-f show notified at 10d. Inside City Limits D.C. Washington 1X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 2129 Young St. S.E. 20020 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 🛣 No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Charles William Sanders Sr. Shelia Renee Parish 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 Is Shelia R.Parish Mother 2129 Young St.S.E.Wash.D.C. 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ŏ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Olivet Cemetery 9-14-07 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 20011 Hunt Fun. Home 908 Kennedy St. NW Wash. DC wanus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Krimaru Sclerosing /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to his mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of was ...
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ves 2 No certificate has death? 1 ☐ Yes 1∐ Yes 2 □ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 NO 1 Junpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending death. investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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State of Maryland / Department of Health and Mental Hygien 2007 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7:49 PM M 2007 September 3, Michael Lee Speaks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 423 E. Patrick Street #15 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 8, 1949 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 58 Wash., Director 578-66-4905 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Frederick Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21701 Patrick St. 423 E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2XNo 1 Yes 28 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Porter James Speaks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Speaks, Jr./Son 7034 Palamar, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 9/14/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crem. 22. Name and Address of Facility Ft. Lincoln F. H. 21. Signature of Funeral Service Licensee 10 3401 Bladensburg Rd., Brentwood, MD 20722 retram 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed physiclen and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending deteched for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who co cause of death (Item 23a) (Type, Print) 0 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31019 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death O Month **Physician** Dianne Genovive Simms 10 2007 11:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Southern Maryland Hospital \mathbf{FG} 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 ☑ F 215-62-9215 53 01/19/1954 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director MD \mathbf{FG} Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4612 Crain Highway 20772 IFA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home-maker Self employed 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hickman Agnes Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Simms - Husband 7319 Monris Road; Brandwine, Maryland 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation _ 5 □ Other (S 3 ☐Removal from State Cheltenham, Maryland 09/17/2007 5 ☐ Other (Specify) MD Veteran Cemetery 22. Name and Address of Facility Freeman Funeral Services Fugeral Setvice License 4594 Beech Road; Temple Hill, Maryland 20748 io's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, also on each line. Approximate Interval Between Onset and Death 23a. Part1. Ententhe disease, or compliant shock, or help it failure. List only one Immediate Cause (Final disease or condition resulting in death) Physician 50000 /Medical Due to (or as a consequence of) Examiner 7 nonconic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1998) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner o eath Pate of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injurv 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: s after death filled in by the

3altimore, Maryland 21215-0036

within 24 hours a
To the Funeral I

State Registrar

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29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack ran; 7503 Surrat Road; Clinton, MD 20735

31. Date filed (Month, Day, Year) 3 2007

29b. Signature and title of certifier

32. Registrar's Signature

Medical

29a. Certifier (Check only

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30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) Mithael V. Crowley MD 610 Dutchmans Lane, Easton, MD 21601		ne Hosp n 24 ho ne Fune bletely fi	edical	(Check only 2 Medical Examin	ner: On the basis of	examination	dge, death and/or inv	occurred a restigation,	in my op	e, date and inion, deat	d place, and th occurred	due to the ca at the time, da	use(s) an ite and pla	id manner as s ace, and due t	tated. the cause(s)	
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30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) Michael V. Crowley MD 610 Dutchmans Lane, Easton, MD 21601)			MATERIA	an / no				D	25,	453		8	30.07	2	
		2		Michael V.			Ва) (Туре, I	Print) Dut	thm	ens L	ane,	Easto	n, M	D 2/6	01	
State Registrar AUG 3 1 2007				31. Date filed (Month, Day, Year) AUG 3 1 20	32 Registra	r's Signature	9	وكامه								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. Year **Physician** Η. Scott Audrey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 26, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X** F New York 78 096-20-7209 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 √ Yes 2 No Director Upper Marlboro Prince Georges 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 13607 Messoula Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 【XNo Specify. þ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of New York 12 License Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Mabel Chambers Ernest H. Pigott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16017 Pennsbury Drive Bowie, MD 20716 of Health Lillian Spelman-Brown/ Sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/7/2007 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Servi 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ON disease or condition resulting in death) Y FARS /Medical Due to (or as a consequence of): Examiner RDIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 2 PNo 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 3□ DOA 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by within 24 hours a edical

Maryland 21215-6036

Baltimore,

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY GREEN BELT MD 20170 31. Date filed (Month, Day,

Registrar

SEP 1 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 23 part 2 per phy State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 9/11/05/odlw State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 10,2007 **Physician** James Skordas 0200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mandrin Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7/26/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** Min. XXM 2 F Months Days Hours 214-05-2248 91 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Gibson Rd. 21401 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? ►CXYes 2 No WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes ŽŽNo Specify. White Completed by Specify 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor USNA Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Skordas Penelope Keramidas ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Skordas Wife 210 Gidson Rd. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 9/13/2007 Lusby, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 77 Ridgely Ave. Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition OISEA15 **Physician** 42613 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Rectal Cancer 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1. Natural Injury

Division or Vital Records, P.O. Box 68760,

funeral director. After this or Attending death. within 24 hours after death To the Funeral Director: in by Hospital

Medical 10 State

Registrar

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 1 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** AM ELIZARETH SHEPHERD SEPTEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner POCOMORE CITI HARTLEY WORCESTER HALL CITY 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 🗷 F 218 22 1354 86 Director WEST VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director VIRGINIA CHINCOTENGUE ACCOMACK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 23336 6208 MAGNOLIA DRIVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No à Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 TH GRADE College (1-4or 5+) PRODUCE PACKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PEARL BAILEY ပ JOHN KIDDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If item 27 is any injury or other trau 2402 GRANDCHILD PAYNE ROAD POCOMORE CITY MARYLAND 21851 KATIE BODLEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State SEPT 14 2007 CHINCOTEAGUE, VIRGINIA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eck & HOLSTON FUNERAL HOME SO49 CHICKEN 23336 CITY ROAD CHINCOTEAGUE, VIRGINIA M. Dole Vox 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) asru Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl To the I

3altimore, Maryland 21215-0036

Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifer

29a. Certifier

29c. License number D54422 29d. Date signed (Month, Day, Year) 09-13-2007

21851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2007



State Registrar

BA 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ^{Year} 2007 12:20 17, September Elsie Rhoda Stambaugh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 ☐ M 2 🖸 F 86 Missouri 272-22-2377 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45853 Carefree Way 20653 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: White \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic evonce. Irwin G. Haddix Theresia Goebel Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45853 Carefree Way, Lexington Park, Maryland 20653 Charles Stambaugh / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery 22, 2007 Edgerton, Ohio 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on ea — inc. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hur 2 No 3 Probably 4 Donknown 1 Tes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death Check only one, Be Other: 4 Nursing Home 1 ☐ Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident after death filled in by the 6 ☐ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check only onel

29b. Signature and title of certifie

(21)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2. the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

07-07296 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Schnople State of Maryland / Department of Health and Mental Hygiene 2007 31025 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 18, 2007 **Medical Examiner** 1712 hrs William Joseph Schnople 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min: Months Hours Director Days 1X M Country) 2 213-98-8895 Nov. France Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once, Maryland Harford Fallston 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Main St. P.O. Box 183 21047-0183 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes Widowed Divorced If Yes, Give Yea Yes 2 X No specify: Specify: White the Medical Examiner ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry turmore, MD 21215-0036

t. Pages 1 and 2 should be filed within 72 hou thent of Health and Mental Hygiene. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Handyman Remodeling 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joseph Michael Schnople Dagmar Maria Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Schnople/Brother 337 Skyline Drive, Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 Removal from State crematory or other place) Hilltop Service Corp. 9-24-07 Towson, Maryland Donation 5 Other Specify: 22. Name and Address of Facility
McComas Funeral Home, P.A. Signature of Funeral Service Licens 317 Cokesbury Rd., Abinadon. Maryland 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED X #45,23a,27,perME,g872, 10/5/07 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as i Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown g Unknown signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should After this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 2 No 1 V Yes 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Other 4 Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending Director: the Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

OCME 2006

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

M.

SEP 2 6 2007

Theodore M. King, Jr., MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

OCME

September 19, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 11:39P M 19 2007 0tto Spielman September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 409 S. Clear Ridge Rd. New Windsor If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1**X** M 2□ F 218-32-6222 Sept. 3, 1932 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 X No MD Carroll New Windsor Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21776 U.S.A. 409 S. Clear Ridge Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after of leath and Mental Hygiene. In 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 TYes 21€ No. Specify þ White Specify: 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flora Otto Charles M. Spielman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 133, New Windsor, MD 21776 Health tem 27 I Kenneth E. Spielman son Department of Heal Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐Removal from State Haugh's Cemetery Ladiesburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 9/24/2007 21. Sig y tu ê of Funeral Service Li 22. Name and Address of Facility Hartzler Funeral Home alparine <u>310 Church St., New Win</u>dsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 100r5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached? 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 → Hiknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No ို 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pendina ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 🚄 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. M Many hote Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 ō

Physician /Medical Examiner burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day MICHAEL PRESTON CLIFTON TARRENCE SEPTEMBER 06, /Medical 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days XXM 2 F Months Hours Director Yrs. 336 66 5625 29 MARCH 22, 1978 ILLÍNOIS Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f sh Medkal Examiner must be notified Directo MD PRINCE GEORGES ▼XYes 2 No GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 7515 MANDAN ROAD #304 Funeral 20770 UNITED STATES 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes XX No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. tXNever Married 2☐ Mamied þ 1 ☐ Yes XX No 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, the MANAGER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL O. TARRENCE SYLVIA LEONA LAWRENCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I DARRYL JOHNSON / COMPANION 7515 MANDAN RD. #304 GREENBELT, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation _ 5 ☐ Other (Specify) ZION CEMETERY 09/14/2007 LANSDOWNE, MD 21. Signature of Fuleral Genrice Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 P. f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): SEVERE THROMBOCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical **HEPATITIS** the IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes YN No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perfori XXNo 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: XX Inpatient 1 ☐ Yes 🏋 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier (Check only one) XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29b. Signature and title of certifier 29c. License number MDD 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (020x6E GREEN GAY CENTER DRIVE 31. Date filed (Month, Day, Year) State 32. Registrar's Signature **SEP 1 3 2007** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 31028 For MD, TCHD, 09/12/07 pha Registrar FH, TCHD, 09/11/07 pha Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Travers 9:10P Robert Michael 09 06 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7460 <u>Jeffreys Wa</u>y Talbot <u>Easton</u> 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** 1 M 2□F Hours Director 116-34-2632 63 09-04-1944 N.YUsual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. 27 is marked other then "natural", or itams 23e or 28e-f show traumatic event, the Medical Event and must be traditived at 1 Pres 2 No Directo Md. Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7460 Jeffreys 21601 USA Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Finance Stock Broker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Patrick Travers Mary Adelgondis Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Welter/ Niece-n-law 5474 Wellington Dr. Trappe, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Capitol Cematory 0 * 4 ☐ Donation 5 ☐ Other (Specify) Dover, De. 09-11-07 21. Sign ture of Funeral Service Licensee Bennie Smith Funeral Home 426 Dover St. Easton, Md. 2 haw rumie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a months metastatic /Medical Due to (or as a consequence of): more than Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE:

detached page 2 should be director. filled in by the funeral

has been signed by

certificate

Attanding Physician:

death.

within 24 hours after deat To the Funaral Director:

completely

Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 🔼 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 200No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 10 1 Tes 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License number

HO059973

29d. Date signed (Month, Day, Year)

10+VA

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

100 Bramble St, Cambridge MC

Months

10f. Zip Code

Deys

1 Yes 2 XNo Specify.

ANNAPOLIS

21401

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

7. Age (In yrs. lest birthday)

43

12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Yeer or Dates:

Yrs.

10c. City, Town or Location

31029

3. Time of Death

Birthplece (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

MARYLAND

06:15 AM

SEPTEMBER 6, 2007

1964

4c. County of Death

10g. Citizen of Whet Country?

UNITED STATES

14. Race - American Indian,

Black, White, etc.

Specify: WHTTE

ANNE ARUNDEL

4b. City, Town, or Location of Deeth

MAY 17,

ANNAPOLIS

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year

Physician /Medical Examiner

ROGER LESLIE TUEL, JR.

REHABILITATION CENTER

5. Sociel Security Number

215-90-6764

10a. Stete

Funeral Director

MARYLAND

11. Maritel Status

10e. Street and Number

Usuel Residence of Decedent

1507-B WEST STREET

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

HERITAGE "HARBOUR" HEALTH AND

ANNE ARUNDEL

1**X** M 2□ F

Funeral Director

other traumatic event, the Medical Examiner must be notified at or 28a-f permit. Peges 1 end 2 should be filed within 72 hours effer death with Deperment of Health and Mental Hygiene.

Important: If Item 27 is marked other than "--- any injury or other traument— any injury or other traument— 238

Physician /Medical Examiner

or Attending Physician: The lew requires that the death certificate be executed ettending physiclen use es the ete hes been signed by the pege 2 should be deteched efter deeth Director: the filled in by 24 hours To the F

Division of Vital Records, P.O. Box 68760.

Completed by 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) CHEF RESTAURANT/FOOD SERVICE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be ROGER LESLIE TUEL, SR. DREAMA FAYE RADA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) CATHY LYNN TUEL/WIFE 1507-B WEST STREET, ANNAPOLIS, MARYLAND 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2007 STEVENSVILLE, MARYLAND STEVENSVILLE CEMETERY 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESIGATE 21. Signature of Funeral Service Lice ROAD, ANNAPOLIS, MARYLAND 21401 M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Be Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end manner steted. 29c. License number 002957/ 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of fertifie

DHMH 16 Rev 6/95

State

Registra

1655 CROFTON BOULEVARD, SUITE 101, CROFTON, MARYLAND 21114-1342

30. Name end eddress of person who completed cause of deet/ (Item 23e) (Type, Print)

32. R gistrer's Signature

PAUL B. BEREZ, M.D.,

SEP 1 1 2007

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of M	Marylar			t of Hea e of De		Mental Hy	giene 0 C	7	31030
ı	Physici /Medi	cal	Decedent's Name (First, Middle, Maximus James 4a. Facility Name (If not institution,	Vekeman		son	4b City	Town or Lo	cation of De		Day	Year 2007	3. Time of Death 6:38 P M
	Examir Funeral Director	ier	Holy Cross Hosp	ital		last birthday O Yrs.	Si	lver i	Sprinc Under 24 H Hours Mi	rs. 8. Date of Birt	Montg	omery 9. Birthpla Country	ce (State or Foreign y)
	Maryland -1 show Ilwa at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Monto	omery	10c. Cit	y, Town or L	ney						d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland rms 23a or 28a-f show	al Director	10e. Street and Number 18131 Marksman		403		10f. Zip		832		10g. Citizen of W US	-	/?
036	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Madical Extended when the received and the problem of the control of t	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force of 1 Tyes 25 If Yes, Give Year or Dates	s? ⊒No	.S. 13.	Was Deced If Yes, spec	offy Cuban, N	nic Origin? Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Black	- American k, White, etc White	C.
1215-0036	within 72 ho ene. than "natur to Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		ır 5+)	(Give	kind of wor DO NOT us	al Occupation rk done durin se retired)	n ng most of w	vorking	16b. Kind of Bu		stry
Maryland 2121	rould be filed Mental Hygid narked other natic event, II	To Be Co	None 17. Father's Name (First, Middle, L Jeffrey Lloyd T	,		Non	e			ame (First, Middle, Jane Veke			
	as 1 and 2 should I of Heath and Men item 27 is marker r other traumatic		19a. Informant's Name/Relationsh Morgan Jane Vek 20a. Method of Disposition				1 Mar	ksman		e, #403,	Olney,	MD 20	832
Baltimore,	permit. Pages 'Department of I Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Sign rurs of Funeral Service L	ecify)	te Sa	emetery, cre ndy Sp eting F	matory or or ring House 2. Name an ranci	ther place) Frience Cemet d Address of	ery (Facily Collin	t. 12, 2007 s Funral	Home In	pring	, Maryland
Į	Pnysician /Medical		23a. Part 1. Enter the disease, of shook, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Respi	line.	h. Do noten y Fail	ter the mode			vd, W., S ac or respiratory ar		A Ir	MD 20901 Opproximate Interval Between Onset and Death
	Examiner Journalit	Examiner	Sequentially list conditions, if my least to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Grade</u> Due to (or a	IV I	ntrave		ular F	lemorr	hage			2 Days 5 Days
68/60,	ficate be executed physician and s the burial-transit	dical	resulting in death) Last	·	oamni	uence of): onitis							5 Days
C. BOX	the death certificate y the attending physi iched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	I death 3	∃Ectopic pro ☐ Other (spe				23d. Date Mon	of delivery th Da	ay Year
cords, P	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant condition Esophageal Atre		but not res	ulting in the u	inderlying ca	ause given ir	Part I.		bacco use contri es 2🗓 No		cause of death?
l Kec	The law te has b	e Completed	25. Was case referred to medical							1 ☐ Yes	sy pr med? de 3/13/No 1	/ere autops rior to comp eath? Yes 2	y findings available bletion of cause of
5	Phys this ral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending	Hospital: 1 🖾 Inpa 28a. Date of In (Month, L		ER/Outpatie 28b. Time o Injury	f 2	A Other: A 8c. Injury at Work?	4 🗌 Nursing	Home 5 Resident Residence			-17
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be	njury - At ho etc. <i>(Specil</i>)	ome, farm, st	M reet, factory		2 🗆 No	28f. Location (S City or Tow	treet and Numbe n, State)	or Or Rural F	Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medicai (29a. Certifier (Check only one) 2 ☐ Medical E 29b. Signature and title of certifier	Physician: To the best xaminer: On the basis and manner	of examina	wledge, deat tion and/or in	vestigation,	at the time, of in my opinion.	on, death oc	curred at the time, o	ause(s) and man date and place, a	nd due to th	ne cause(s)
c	2		Sucrem C 30. Name and address of person w			23a) (Type	D		671		1	107	
	Sta	ite	Sharon Kiernan, 31. Date filed (Modar Day, Year)	M.D. 15	00 For	rest G	len Ro		Silver	Spring,	MD 20910)	
	Registr	ar	API TY	LUU!		KA	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** September 07, 2007 0530 Melvin Sidney Thaler /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min Examiner Montgonen Brooke Grove Rehabilitation and Nursing 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** 1X M 2□ F 046-03-7820 Jan. 3, 1918 NY Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State rthen "naturel", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Montgomery 01ney 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20832 United States 16821 Cashell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1937 − If Yes, Give Year or Dates: 1970 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Air Force Officer permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Importent: If Item 27 is marked other th any njury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Thaler Solomon Frederick Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16821 Cashell Road, Olney, Maryland 20832 Fred Thaler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/7/2007 Alexandria, Vircinia 21. Signature of Funeral Pervice Lice 22. Name and Address of Facility DeVol Funeral Home IO East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ducterial pneumonia
Due to (or as a consequence of): days bacterial /Medical Examiner obstructive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ettending physicien and for use as the buriel-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an tai lure autopsy perform 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funarel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٢ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1. Natural 1 Tes 2 🗆 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

8+1

State Registrar

29b. Signature and title of certifier

way Brooke

31. Date filed (Mon

w.

2007

DHMH 17 Rev 1/2001

18100 Stade School

STAFF PHYSICIAN

address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State Registrar		Ce	ertificate of		ivientai Hyg	eg. No 2007	31032
*	Physici	an	1. Decedent's Name (First, Middle, La Sidney	Terry				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give			4b City Town o	or Location of Dea	Sept.	2, 2007 4c. County of Deat	1:25P M
A.	Examil	er	Southern Mary	,	pital		nton		P.G.	
	Funeral Director		5. Social Security Number 242-02-0777 6. S	Sex 7. Ag	e (In yrs. last birthday O Yrs.		If Under 24 Hrs Hours Min		, Year) 9. Birt	hplace (State or Foreign untry) sh. DC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryll f sho	tor	Md. P.G.			ct Hgts				1 X Yes 2 No
	h the or 28a	irec	10e. Street and Number		<u> </u>	10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a c	ral	6925 Halleck	Street		20	747		U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 3554 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.
5	"natu	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of we	orking	16b. Kind of Business/	Industry
12	within ene. than he Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5	ı+ì I	aint. Wo			Self-Emp	oloyed
5	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)				me (First, Middle, I		
Vlar	uld be Menta arked atic ev	To B	Charles Te	erry			Nell	ie Spai	n	
Maryland	12 sho n and risma rauma		19a. Informant's Name/Relationship (600				r, City or Town, State, 2	
	1 and Healti em 27		Gregory Reave	s/Brothe	-	osition (Name of ematory or other place			20c. Location - City or	
Baltimore,	Pages ' Iment of H tant: If ite jury or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Special</i>	y)	Riverda	le Park	9/1		Riverdale	
Ba	permit Depar Impor any In		21. Signature of Funeral Service Lice	1	~	2. Name and Addre	use of	William treet,	s Fun. Sv	c.
68760,	Physician /Medical Examiner as the prival-transit as the brial-transit	al Examiner	23a. Pa. 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, It as year and to final disease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b.	a consequence of):					Interval Between Onset and Death
P.O. Box	death cert	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions of	4□Pregnant at 9□Unknown	2 ☐ Fetal death 3 [time of death 5 [□Ectopic pregnanc; □ Other (specify) _		23e. Did tol	23d. Date of del Month	Day Year
rds	quires n sign ald be	d by							es 2 No 3 Pr	١
Vital Records,	rician: The law requires that the cortificate has been signed by the irector, page 2 should be detache	Completed						24a. Was a autops perforr 1 Yes	ned? death?	topsy findings available completion of cause of
	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt ER/Outpaties	nt 3 DOA Oth	or:	ath (Check only on		
ō	g Phy er this eral d	\vdash	27. Manner of Death	28a. Date of Injur	ry 28b. Time o	III JUDOA	4 Li Nursing i		ence 6 Other (Specow injury occurred	cify)
<u>S</u>	ending lath. or: After he funer	atio	1 Natural 5 Pending 2 Accident investigation		Year) Injury		K? Yes 2 □ No			
Division or	al or Attend s after death al Director: , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	rry - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 Decrtifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination and/or in	th occurred at the til ovestigation, in my o	me, date and place opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Monti	h, Day, Year)
)			7	· Ludedie	nD	Ds	0689		09/02/2	007
			30. Name and address of person who			Print) ANIL	KMA	HAJAN.	MD	
	Sta	e.	Snh Hc . 7503 31. Date filed (Month, Day, Year)	32. Raistra	ar's Signature		UN M	D 207	35	
	Registr		SEP 1 2 2	007	K 1	Co. B.				

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Rajbinder S. Gill, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

29c. License number

29d. Date signed (Month, Day, Year) 9-17-07

8

29b. Signature and title of certifier

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept :00 am JOHN LINDSEY WALTER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Plata Charle Civista Medica Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-17-1934 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 1 M 2 □ F Days Hours Min. Months WASH., DC 579-42-8773 73 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Ye**5** 2 □ No MD. CHARLES WHITE PLAINS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11074 ELLINGER DRIVE 20695 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces: 1 ▼Yes 2 No If Yes, Give ARMY Year or Dates: 1958 Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED WAY Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF DATA PROCESSING NAT. CAP. AREA 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ADAM LINDSEY WALTER GENEVIEVE R. LINTHICUM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILLIE WALTER-SPOUSE 11074 ELLINGER DR. WHITE PLAINS, MD. 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 9-26-07 WALDORF, MD. M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licenses LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY disease or condition resulting in death) OBSTRYCT/UE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ASPIRATION IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (CE REBRO DASCULAR ACCIDENT) 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performed? 1∐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No DEMENTIA 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3∏ DOA

Physician /Medical Examiner P.O. Box 68760, requires that the death certificate be

3altimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

must be ral", or items 23a Examiner must b

than,

Department of Health and Men Important: If Item 27 is marke any injury or other traumatic

Pages 1 and 2 should be f nent of Health and Mental I

Director

Funeral

Completed by

Be

P

Examine

the burial-tran physician as t attending properties for use as use the signed by page 2 should be certificate or Attending Physician: funeral director, After

Division or Vital Records,

Physician/Medical Completed 25. Was case referred to medical Be examiner? 1 Yes 2 No မှ 27. Magner of Death Certification: Natural 2 Accident

3 ☐ Suicide

(Check only one)

Nothin 24 hours after death.

To the Funeral Director: Af the Hospital Medical

Registrar

28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/21/07 D 2117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Primary Care 3460 Old Wash, Rd Suite 2034 majure Waldorf, MD 20602 Sharma 31. Date filed (Month, Day, Year) SEP 2 6 32 Registrar's Signature 2007

			1 - Stete Registrer	State of Mar		artment of I			iene •g. No 2 N N 7	31035
	Physici		1. Decedent's Name (First, Middle, Last)	ilson				2. Date of Deat Month September		3. Time of Death 7 10:26 a.M.
1	/Medio Examin		4a. Facility Name (If not institution, give s 920 Harlan Avenue	treet and number)		, ,	or Location of Dez erdeen	ath	4c. County of Dea	
	Funeral Director		233-14-0403	7. Age (i	In yrs. last birthday) Yrs.	If Under 1 Year Months Days			Year) C	rthplace (State or Foreign ountry) O
	Maryland B-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harford	1	Oc. City, Town or Lo		237797			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28	al Director	10e. Street and Number 920 Harlan Ave.			10f. Zip Code 21001		1	0g. Citizen of What C	Country?
980	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Notice Value 4 Divorced	I2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XD No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ② No	oan, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Wh Specify: W	
Maryland 21215-0036	within 72 hou ene. then "netura he Medical E	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Business Nursing	s/Industry
land 2	Z z z Z	To Be Co	17. Father's Name (First, Middle, Last) Garth Allen Sou	lt	races			ame (First, Middle, i	Maiden Surname)	
	D = 7 = 0		19a. Informant's Name/Relationship (Ty) Barbara A. Church	(Daughter	1108	Broadmo		Rural Route Number Bel Ai	; City or Town, State, r, Marylar	^{Zip Code)} nd 21014
Baltimore,	permit. Pages 1 en Department of Heal Important: If item 2 any injury or other <u>once</u> .		20a. Method of Disposition **Data Communication** 2	emoval from State	Harford M	matory or other pla lem. Gdns	9/2	6/07 A	20c. Location · City o berdeen, N	
Baj	permit Depar Impor any in		21. Signature of Funeral Service License	ustral				neral Hom nd 21001		Approximate
8760, S	Physician Medical Examiner Physician and burial-transit Streep Physician and streep Physician and streep Physician Phy	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a compute to (or as a comp	consequence of):	Cance	e m	etart	xtic	Interval Between Onset and Death
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	The law requires that the table has been signed by sage 2 should be detected.	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause g	ven in Part I.	23e. Did tol		to the cause of death? Probably 4 Anknown
al Reco		Completed	•					24a. Was a autops perfori Yes	ned? prior to death?	autopsy findings available completion of cause of us 2 \square No
Division of Vital Records,	nding Physician: Th. th. : After this certificel stuneral director, p	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 Vo H 27. Manner of Death 1 Actural 5 Pending 2 Accident investigation	ospital: 1 lnpatient 28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Inju	her: 4 Nursing		ence 6 Other (Sp ow injury occurred	ecify)
Divisi	dea dea / the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, sti (Specify)			28f. Location (Si City or Town	reet and Number or F n. State)	Rural Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Direction polyletely filled in by	edicai	29a. Certifier (Check only one)	ner: On the best of e ner: On the basis of e and manner state	kamination and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To I To I	Z	29b. Signature and title of certifier	= Ziazi	Wilsor N		LUCJO	\	9d. Date signed (Mor	- 2007
	25		30. Name and address of person who co	10,670	111-0	Print) les C	07,1	wion,	WN 5	1204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2007	Registrar's	S Signature	all of				

		1	For State Registrar	tate of Maryland		nt of Health and I te of Death		jiene 2007	31036
		_	Decedent's Name (First, Middle, Last)	\	. 1		2. Date of Deat Month	Day Year	3. Time of Death
	iysicia Medica	al .	Beverly	\V	horton	Town and position of Doort	09	4c. County of Deeth	7.09pm
B.	camine neral		te. Facility Name (If not institution, give stre Levin Manor 5. Social Security Number 6. Sex	7. Age (In yrs. las	enter Cu	Town, or Location of Death The Location of D	8 Date of Birth	Alles (polace (State or Foreign
	ector		214-34-2131	^{2,©} ¥ 67	Yrs.	Day's Hours William	Oct 11	, 1939	MD
and w	_	-	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Maryli -f eho	Beda	to	MD Allegany		Cumberla	nd			1 ⊠Yes 2 □ No
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ath wil	dian	ral	730 Furnace Street		10 Was Day	21502	Specify Ves or No-	USA 14. Race - Ame	rican Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hysten. The marked other then "natural; or items 23a or 28a-1 show	Xardiner.m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1	If Yes, sp	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 2 No Specify:	to Rican, etc.)	Black, White	e, etc.
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215 ithin 7	Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	'iite. DO NOT Cook	use retired)		Finan Cente	er
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y, Maryland 21215-0036 and 2 should be filed within 72 hours af eath and Mental Hygiene.	r trauma		19a. Informant's Name/Relationship (Type. Brenda Kane	daughter	19b. Mailing Addre 52 Cresce	ss (Street end Number or Rent Rd. Apt E	ural Route Numbe Greet	nbelt V	ID 20770
Baltimore, permit. Pages 1 ar Department of Hea	ry or othe		20a. Method of Disposition 1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	CON	ce of Disposition (A metery, crematory of dale Cemet	r other place)	9/24/2007	20c. Location - City or Flintstone	Town, State
Balti permit. Departm	any inju		21. Signature of Furreral Service Ligensee	4011	22. Name	and Address of Facility Carpelli Funeral I 08 Virginia Avent	Home, PA	rland, MD 2150)2
Phys /Me	ician dical		23a Panti. Enter the disease, or complications, for heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. cause on each line. Drawnt Due to (or as a conseque	Do not enter the m	ode of dying, such as cardia	c or respiratory ar	rrest.	Approximate Interval Between Onset and Death
	niner	er	Sequentially list conditions, if any, leading to immediate	OF FRD	ser				1 yr
8760, Cr	physician and s the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
Box 6	attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ne 9 □ Unknown	c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3□Ectopic			23d. Date of de Month	livery Day Year
P.C	ed by the a		Part II. Other significant conditions contr	ibuting to death but not resul	tting in the underlyin	g cause given in Part I.	23e. Did t	tobacco use contribute t	o the cause of death?
ds,	06	d by	CUA, COP	D (severe)	alty	einen	LEY	Yes 2□No 3□P	robably 4 Unknown
of Vital Records, Physician: The law requires t	ate has been si page 2 should	Completed			/		24a. Was auto perfo 1 Yes	psy prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
ital	is certifica director, p	Be	25. Was case referred to medical examiner?	a-itali		Other	eath Check only		
n of Vita	pis d	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	spital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 4—Nursing 28c. Injury at Work? 1 Yes 2 No		idence 6 ☐Other (Sp. how injury occurred	ecify)
Division To the Hospital or Attending within 24 hours after death.	l Director: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street, fac		28f. Location (City or To	(Street and Number or F wn, State)	Rural Route Number,
Div To the Hospital or A	To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Examine	cian: To the best of my knover: On the basis of examination and manner stated.	wledge, death occur ion and/or investiga	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a , date and place, and du	as stated. se to the cause(s)
thin 2	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	nth, Day, Year)
T X	Ĭ 8		> Steller	i ho		D001756	5	Sept. H	,2007
	4		10		23a) (Type, Print) May X	Hay Lz Cz			
	* St Regist	ate	31. Date filed (Month, Day, Year) SEP 2 6 2007	npleted cause of death (Item	disease of the second				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Willie Robert Waiters 9, 2007 September /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Center Prince George's Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 91 Yrs. **Funeral** Days Months Hours 1**⊠**M 2□F 7/22/16 Director 704-16-4129 Lancaster S.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show be notified at Md. P.G. Capitol Heights Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 6010 Jefferson Heights Drive 20743 U.S.A. 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1★1 Yes 2 □ No
If Yes, Give Year or Dates: 145 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator Construction 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Waiters Hester Mackey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ursula Harden/Granddaughter 7210 Hawthorne St., Landover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 9/19/07 Cheltenham, MD 22. Name and Address of Facility
H.S.Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee any 20019 4925 Burroughs Ave. N.E. Wash. D.C. 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760 physician 9 Physician/Medical the The law requires that the death certificate as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown After this certificate has been signed by i funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Tes 1 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th (Month, Day Year) 1 Latural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 🗌 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier se of death (Item 23a) (Type Frint) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 8:30 P.M 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BETHESDA Vear | If Under 24 Hrs. SUBURBAN HOSPITAL MONTGOMERY 8. Date of Birth (Month, Day, Year) JULY 23, 1917 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛱 F 90 577-48-4667 Director Usual Residence of Decedent 10c. City, Town or Location works 10a, State 10d. Inside City Limits 7 is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery MD Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 Montrose Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. \$ Specify: Black 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker DC PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Martin Bertha Graves ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health important: If Item 27 I Lila Stroud/Daughter 2013 Hayden Road Hyattsville, MD 20782 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cem. 9/14/2007 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME, INC. Washington, 4217 9th St, NW 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muema **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but, not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Levelvorusculu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 Q-No Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Ker Billie Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) of certifier 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 10 0-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgh, MD. 8600 Old Georgetown Rd Bethesda, MD. 20814 31. Date filed (Month, Day, 32. Registrar's Signature State SEP 1 3 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2007 **Physician** SEPTEMBER 19 4:25aM Alfred Wall John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital

5. Social Security Number 6. Sex St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F South Carolina 02/14/1941 250-60-2185 Director 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20636 42602 Clover Hill Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. Baltimore, Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales Retail Salesman 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporabit: if Item 27 is marked oth any injury or other traumatic event once. Be Eula Burnette Ellis V. Wall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 400 Walls Circle, Chesnee, SC 29323 Patricia Moore Wall/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. View Baptist
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2007 Boiling Springs, SC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 20650 /MO1206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ESTIRATORY FAILURE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): DAYS Examiner ANOXIC ENCEPHALOPATMY Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wriknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed' 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hosp....
within 24 hours after dearn.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D56096

Registrar
DHMH 17 Rev 1/2001

State

JOHN ALFRED WALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

SEP 2 C

DR. RAJBINDER GILL SHAH ASSO. HOLLYWOOD MD

State of Maryland / Department of Health and Mental Hygiene Pedro Adolfo Zeceme-Chavez 2007 31040 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day Year September 11, 2007 Physician/ 1959 hrs Pedro Adolfo Zeceme-Chavez Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1964 Guatemala Director 43 2 F none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 Silver Spring 28a-f show Montgomery items 23a or 28a-f shovist be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20901 Guatemala 8617 Piney Branch Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-4. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Yes Specify: White 1 X Yes 2 No specify: Guatemalan f Yes. Give Year Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b: Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Asbestos Removal Co Laborer 21215-0036 6th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pedro Vidal Zecena Clara Luz Chavez Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8311 Roanoke Ave., #3 Takoma Park, Md. 20912 Baltimore, MD Enrique Zecena (Brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Santa Catarina X Burial 2 Cremation 3 Removal from State Sept. 19, 2007 Mita, Guatemala Family Cemetery Other Specify. I4th St., 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Washington W. H. Bacon Funeral Home, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medical Obstruction of Airway by Food Immediate Cause (Final disease _xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed sician/Medical AMENDED UNPENDED ned by the attending physician detached for use as the burial 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 ✔ No 3 Probably 4 Unknown ρ Completed 24b. Were autopsy findings available Records, 24a, Was an prior to completion of cause of autopsy performed? death? has page 2 s Yes 2 V No 1 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Other: Nursing Home 5 Residence 6 Other: examiner? Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Sep 11, 2007 28b. Time of Injury 28c. Injury at Work? After 1 27. Manner of Death Subject choked on food Certification: 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be or Town, State) 8617 Piney Branch Road, Silver Spring, MD Suicide determined (Specify) Residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 12, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature v. Year) Registrar

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of r ertificate of	deaith and Mental Death	Hygier Reg. N		31041
	Physic	ian	1. Decedent's Name (First, Middle, La Sara Virginia And				2. Date	of Death th MBER	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Saint Joseph		Commende and	4b. City, Town, o	or Location of Death		4c. County of Death	
	Francis	F	5. Social Security Number 6. S		Center) If Under 1 Year	TOWSON	of Birth	O Dieth	i morre
	Funeral Director		218-10-9972	1□M 2ĂF	89 Yrs.	Months Days	Hours Min. (Mor	15 , 19	ar) Coui	imore,MD.
	yland how at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L				1	10d. Inside City Limits
	the Mar 28a-f s otiffed	ector	Maryland Howard 10e. Street and Number	County	Glenwoo			10= (Citizen of What Cou	1 Yes 2 No
	th with 23a or ust be r	al Dir	15505 Cattail Oak	S		10f. Zip Code 2.	1738	Tog. (U.S.A.	itry:
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:	or No- tc.)	14. Race - Americ Black, White, Specify:	
15-0	in 72 h	oletec	15. Decedent's E (Specify only highest gra	ade completed)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of working d)	16b.	Kind of Business/In	dustry
212	ed with ygiene. er thar t, the N	Comp	Elementary/Secondary (0-12)	College (1-4or 5- rn/a	+)	sistant 1	Manager		rst Natio	nal Bank
land	ld be file ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last Thomas Ernest Bro				18. Mother's Name (First, I Sara Elizabe			
Maryland 21215-0036	und 2 shou alth and M 27 is mar er traumat	-	19a. Informant's Name/Relationship (Mr. Thomas L. And		19b. Maili 1550	ing Address <i>(Street</i>)5 Cattai	l and Number or Rural Route l Oaks Glenv	Number, City VOOd , M	y or Town, State, Zip aryland	21738
Baltimore,	Pages 1 annent of Herant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		20b. Place of Disponderery, creenetery, cr	osition (Name of ematory or other pla neral Char	Sept. 26,		Location - City or To rest Hill	own, State , Maryland
Balt	permit. Departr Imports any Inj once.		21. Signature of Funeral Service Lice	nseef gav	i, Dr. F	2. Name and Addresses Peaceful 2	Alternatives I Road Timor	Tunera	1&Cremati	on Ctr.,P.A
			23a. P. 17 En r the dise lse or com sh , or hear failur eist only	plications that caused one caused on each lin						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	RENAL FF	AILURE				Onset and Death
*	Examiner		Sequentially list conditions	SEVERE	MALNUTE	NOITI				
J	uted d ansit	Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing doubt).		PARESIS					
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68760,	tificate g physi as the l	ledical		d						
P.O. Box	ath cer tttendin or use	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 [□Ectopic pregnanc □ Other (specify) _	у	_	23d. Date of delive	ery D <i>a</i> y Year
rds, P	equires that the de en signed by the a ruld be detached f		Part II. Other significant conditions of SPINAL STENOSIS	contributing to death bu	t not resulting in the u	underlying cause giv	ven in Part I. 23e	Did tobacc	o use contribute to t	he cause of death?
Vital Records,	hysician: The law requir his certificate has been si I director, page 2 should t	Completed by						. Was an autopsy performed Yes 2	prior to co death?	opsy findings available impletion of cause of
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2∏ER/Outpatie	nt 3□ DOA Oth	26. Place of Death (Check ner: 4 ☐ Nursing Home 5 ☐		6 DOther (Specie	6.1
n or	ding Phy h. After this funeral c	on: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Inju Wo	ry at 28d. Des		ijury occurred	<u>y)</u>
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, st . <i>(Specify)</i>	1000	Yes 2 □ No 28f. Loca City	ation (Street or Town, Sta	and Number or Rura ate)	al Route Number,
	e Hospital 124 hours a e Funeral letely filled	ledical Ce	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best on the basis of and manner state	examination and/or in	th occurred at the tinvestigation, in my	me, date and place, and due opinion, death occurred at the	to the cause e time, date a	e(s) and manner as s and place, and due t	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens		29d. [Date signed (Month,	Day, Year)
)	/		30. Name and address of person who	completed cause of de-	oth (Item 22c) (Time	D37	254		1/25/0	<u>'</u>
	り		BOON POH LIM,	1. D. 760	1 OSLER		TOWSON, MARY	LAND	21204	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2007		r's Stornature	20				

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a)

Year)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director

	Please Type or Pri				•	_				
	1 - State of M Registrar		artment of Heal			ne 2007	31043			
ian	1. Decedent's Name (First, Middle, Last) Richard W. Ater				2. Date of Death	Day 2007	3. Time of Death 3:25A M			
cal ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of Death				
	Casey House Montgomery Ho		Rockville			Montgomer				
	5. Social Security Number 214-40-3968 6. Sex 1 M 2 F 7. As Usual Residence of Decedent	ge (In yrs. last birthday) 65 Yrs.		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Ye 6/10/194	ear) Cou	nplace (State or Foreign untry) yland			
	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits			
ctor	MD Baltimore	Baltimore	:				1 ☐ Yes 2 💢 No			
Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	untry?			
eral	9506 Harford Road 11. Marital Status 12. Was Decedent	Everin II C 12.1	21234	in Original (Co.	=:6: V== == N=	USA 14. Race - Amer	ican Indian			
Fu	11. Marital Status 12. Was Decedent Armed Forces 1 1 Never Married 2 Married 1 □ Yes 2 1 □ Yes 2 1 □	No No	Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto	Rican, etc.)	Black, White				
d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □ Yes 2X No <i>Spe</i>	ecify:		Specify: WI	hite			
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of worki	ng	b. Kind of Business/I	·			
S	12 2	eal Estate	2							
Be	17. Father's Name (First, Middle, Last) Gideon D. Ater	den Surname)								
₽	19a. Informant's Name/Relationship (Type. Print)	ia M. Gruber ural Route Number, City or Town, State, Zip Code)								
	John F. Fader, II / POA		ound Oak Rd				p code)			
	20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State	Date 20c. Location - City or Town, State								
	4 ☐ Donation 5 ☐ Other (Specify)	′2007 Tov	wson, Mary	/land						
	21. Signature of Funeral Service Licensee	·	2. Name and Address of F UCK TOWSON	•	Towson, Home, In	, Maryland nc. 1050 \	d 21204 York Road			
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not ent ne.	er the mode of dying, suc	ch as cardiac o	r respiratory arrest,		Approximate Interval Between			
	resulting in death)	ostate Can	cer				Onset and Death			
	Due to (or as	a consequence of):								
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):								
Examine	that initiated events c.									
	Due to (or as	a consequence of):								
edic	d			_						
n/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant		3⊢. .			23d. Date of deliv	/ery			
Physician/Medical	1 Yes 2 No		Ectopic pregnancy Other (specify)			Month	Day Year			
Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death b	out not resulting in the or	nderlying cause given in F	Part I	23e Did tobace	co use contribute to	the cause of death?			
Completed by			ison, ing cause given in		1 ☐ Yes		babiy 4XXUnknown			
24a. Was an 24b. Were autopsy findings a										
autopsy prior to completion of death? □ Yes 2 □ No 1 □ Yes 2 □ No										
Be C	25. Was case referred to medical examiner?		26. I	Place of Death	(Check only one)	10103	20.110			
ြ	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatie					e 6 XIOther (Spec	_{ify)} Hospice			
ion:	27. Manner of Death 1	ary 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		28d. Describe how is	njury occurred				
ficat	3 Suicide 6 Could not be determined 28e. Place of inj	ury - At home, farm, stre			28f. Location (Stree	t and Number or Rui	ral Route Number,			
Medical Certification:	4 _ Hornicide Building, et	c. (Specify)			City or Town, S	tate)				
dical	29a. Certifier (Check only one) 1 🔀 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or inv	n occurred at the time, da vestigation, in my opinion	ite and place, a n, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
Me	29b. Signature and title of certifier	/	29c. License num	ber	29d.	Date signed (Month	, Day, Year)			
	Ineriane Who War	ski her	00064615	5	9	/24/2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									

State Registrar Gen Wroblenski 6 31. Date filed (Month, Day, Year) SEP 2 7

2007

Oj

DHMH 17 Rev 1/2001

6001 Muncaster Mill Rd Rockville, Md. 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GP TENBER 900 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORA 600D SAMAR ITAN HOSPITAZ If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 44-2913 Days Months Hours Min. 1 □ M 2 7 F Director unk Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shov iner must be notified at 1 X Yes 2 □ No Director altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral ona Was Decedent Ever in U.S Armed Forces? 1 Yes 2 NNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1/2 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 1ac Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surnathe) Be wyc 19a. Informant's Name/Relationship (Type. Print) (Guarantor) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1200 4 Donation 5 Dother (Specify) 21. Sigrature of Funeral Service Licenses 22. Name and Address of Facility S. Funeral Ho Ave. Balto. WINCETh 23a. Parl . Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart . litre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACOUIRED IMMUN3 DOFICENCY /Medical Due to (or as a consequence of): Examiner 1+1 V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> RENDZ 1 Yes 2 No 3 Probably 4 Unknown Completed PNEUMONIA WITH RESPIRATUR 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 NO 1 Hnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c, License number 29b. Signature and title of ertifier ATTONDING 29d. Date signed (Month, Day, Year) D00622 PHYSIC(A) TONBOR 11 2007 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 00 SAMAR17AN M.D TIMORE

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Registrar

State

Registrar

SOSANTA

31. Date filed (Month, Day, Year)

A OCYGMISI

m. D

32. Registrar's Signature

LIBERTY HEIGHT MR BRITIMONE MD 21215

State of Maryland / Department of Health and Mental Hygieney 0 0 7

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment of F tificate of	lealth and l Death		glene2007 Reg. No.	31047
Ų.	Physici	an	1. Decedent's Name (First, Middle, La Perpetua Em	_	Bua	oob		2. Date of De. Month July	ath Day 2007	3. Time of Death 1:54a M
187	/Medic	al er	Perpetua Em 4a. Facility Name (If not institution, giv Prince George			4b. City, Town, o	r Location of Death		4c. County of Dea	
			Prince George ' 5. Social Security Number 6. S			Cheve		8 Date of Birl		rthplace (State or Foreign
	Funeral Director			1□ M 2√2 F 76	Yrs.	Months Days	Hours Min.	Jan. 2	2,1931 9. Bi	shana Chana
	tryland show		10a. State 10b. County		_{y,Town or Loo} Jashin					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma 28a-f	Director	D.C.		asiiiii	10f. Zip Code			10g. Citizen of What C	
	th with	al Dii	706 Parkside P	lace			019		USA	,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	i .	Was Decedent of H f Yes, specify Cub I ☐ Yes 2 🛣 No	lispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc. Black
2-0	72 ho "natur dical f	eted	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occup	ation during most of world)	king	16b. Kind of Business	s/Industry
21215-0036	filed within Hygiene. After than "ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	1	acher	<i>1)</i>		Educat	cion
	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last		•				Maiden Surname)	
Maryland	12 should be f and Mental I Is marked of raumatic eve	To	James Emmanuel 19a. Informant's Name/Relationship (19b. Mailin	a Address (Street	Anna P	-	er. Citv or Town. State.	Zip Code) 20875
	1 and 2 s Health an iem 27 is		Felicia Buadoo		ter					everly, Md.
lore	iges 1 if item or oth		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Romoval from State	cemetery, cren	sition (Name of natory or other pla		Date /2007	20c. Location - City o	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		4 ☐ Donation 5 ☐ Other (Special Service Lice			f Heave		/2007	AL SERVIC	Spring,Md
B	Dep Imp	_	* Xuly D to	unt	92	41 Colu	ımbia Bl	vd Sil	ver Sprin	ng,Md20910
			23a. Fart1. Enter the risease, or comshock, or heart ailure. List only	plications that caused the deat one cause on each line.	h. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Non Small Due to (or as a conseq		Cancer	of Lung			2 yrs
	Examiner	U	Sequentially list conditions,	_{b.} Brain Meta		.S				1 mo.
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uenes-ory:					
, , ,	tificate be executed g physician and as the burial-transit	I Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	ficate by physic is the b	edical		▲d						
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	aldeath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute Yes 2⊠No 3⊟I	to the cause of death? Probably 4 ∐Unknown
Vital Records,		Completed						1□ Yes	psy prior to ormed? death? 2 ☑ No 1 ☐ Ye	
Vit	Physician: r this certificaral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatien	t 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H		one) dence 6 □Other (Sp	pecify)
n or	6 6		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?		how injury occurred	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 29a Bloom of injury At h	ome, farm, str		Yes 2 □ No	28f. Location (Street and Number or I	Rural Route Number.
Div	al or A s after al Direct	Sertif	4 Homicide determined	building, etc. (Specia	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical (hysician: To the best of my knominer: On the basis of examination and manner stated.						
	Vithi To th	Ž	29b. Signature and title of certifier	1/1/1/1		29c. Licens	e number 3957		29d. Date signed (Mor	• • •
•	n		30. Name and address of person who	completed cause of death /lter	n 23a) (Tvne		177		July 23,	2007
_	12		Gary Little MD	3001 Hospi	ital D	rive Ch	everly,	Md 207	85	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2. 7. 201	33. Registrar's Signa 07	ature	AP a				
	3		2 (201	AMERICA KI	feet side					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31048 Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day /Month Year **Physician** September 1:35 am Harold Boericke 22,200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Ursing taure do Grace Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 30, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ₹ M 1/2 □ F Pennsylvania 206-14-7760 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show s 23a or 28a-f show rust be notified at 1 ☐ Yes 2√ No Director MD Harford Havre de grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 415 S. Market Street 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer mechanical permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, <u>tt</u> unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 N. Hickory Avenue Bel Air, MD Mark Carroll/Comm on Aging 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signatur⊧ of E neral S S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 25a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dration /Medical Due to (or as a consequence of): **Examiner** 2 Sequentially list conditions, if any, leading to infline diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecu Examine burial-tran Due to (or as a consequence of) physician Physician/Medical as the ! IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2: autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

the death certificate be executed Vital Records, P.O. Box 68760, Harold Division or

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

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the

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Medical

(Check only one)

29b. Signature and title of certifier

Wham.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Revolution St. Havre De Grace MD 21078. Milhanimo 31. Date filed (Month, Day, Year) SEP 2 7 2007

and manner stated.

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20, 2007 10:55 AM September Owen Brady 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1**∑** M 2□ F 83 297-16-5702 Dec 2, 1923 Indiana Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Hunt Valley 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12007 Boxer Hill Road 21030 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 142–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un . 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Brady Hulda Elizabeth Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Brady/spouse 12007 Boxer Hill Road HuntValley, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 Other (Specify) 21. Signa ure of Front 1 Tryice Licensee Konald S Water 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director races 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE Immediate Cause (Final YEARS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

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r than "natural", or Items 23a or 28a-f shov the Medkal Examiner must be notified at

filed within 72 hours after

ene.

Pages 1 and 2 should be filed vent of Health and Mental Hygieint: If Item 27 Is marked other t

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any lighty or other traumatic evonce.

Baltimore, Maryland 21215-0036

as the burial-tran been signed by the attending physician should be detached for use as the buria Physician/Medical Completed by cate has t page 2 s this certificate director, Be 2

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury 28b. Time of (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence State (Specify HOSPICE 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

Certification:

Medical

Ecritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifler-

064395

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIENE DOBERMAN, NO 6565 N CHAPLES ST, BUTE 216 BACTMORE, NO 21204 31. Date filed (Month, Day, Year)

State Registrar

SEP 27 2007



To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After

completely filled in by the

			For State	State of Maryla		artment of H			ene . No 2007	31050
Ė	Physici	an	Registrar 1. Decedent's Name (First, Middle, L	ast) ROBERT		BAKER		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gr	 		4b. City, Town, or	Location of Dea		25 2 007 4c. County of Dea	2:20 A M
	Examin	er	CARROLL LUTHE				INSTER		CARROL	
	Funeral Director			Sex 7. Age (In yrs	s. last birthday) 86 Yrs.			8. Date of Birth (Month, Day,)	9. Bir	tholace (State or Foreign
			Usuel Residence of Decedent					10/10/	1020 PAD	5
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e Ma	ctor	MD CARRO)LL	WESTM	INSTER				1 X Yes 2 □ No
	ith th	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	ath w			ARK WAY, APT.		211.			USA	
36	d within 72 hours after death with the Maryland jiene. r then "natural", or iteme 23a or 28a-f ehow the Modical Exacilizer mest be inclified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give		Was Decedent of Hi If Yes, specify Cuba 1□Yes 2⊠No	ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Bleck, White Specify: WI	e, etc.
15-0036	hour		15. Decedent's I	Year or Dates:	16a, Dece	dent's Usual Occupa	ation	16	Sb. Kind of Business	/Industry
Ç	n ne	Completed	(Specify only highest g	rade completed)	(Give	kind of work done of DO NOT use retired	during most of we	orking	D. Hand of Basinosa	
212		mo	Elementary/Secondary (0-12)	College (1-4or 5+)	WAREI	HOUSE LE	EADER		WAREHOUS	SE
ğ	ild be filed lental Hygi ked other ic event, II	Bec	17. Father's Name (First, Middle, Las	•				me (First, Middle, Ma		
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Maryland 2121	es 1 and 2 should to of Health and Ment litem 27 is marked rother traumatics		19a. Informant's Name/Relationship	(Type, Print)						Zip Code)21158'
	and lealth m 27		GERTRUDE BAKE				RK WAY	· · · · · · · · · · · · · · · · · · ·		NSTER, MD
9	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, crei	sition (Name of matory or other place	e)	Date 20	c. Location - City or	Town, State
Baltimore,	tmen tant:		4 Donation 5 Other (Spec					/26/07 SY		
E E E	permit. Page Department Importent: If eny injury or		21. Sign ture Service Lice	ensee				LETCHER I ,WESTMIN		HOME, P.A. 21157
			23a. Part1. Enter the disease, or conshock, or heart ailure. List ont	mplications that caused the dea y one cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- a	Metost	25ic /	Adeno(annons		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
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	uted 1 Insit	H I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	, ,					
~	ate be executed hysiclen and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
9/9	ysicle	dicai		d						
٥	tifical ng ph as th	Medi								
XOR	death certific e attending p od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of de	
o n	et the dea by the at stached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
7	thet the	Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	the cause of death?
ds,	8 5 8	d by						1 ☐ Yes	2, No 3 □ P	robably 4 Unknown
Hecord	w require been si should b	iete						24a. Was an	24b. Were a	utopsy findings available
	e h d e b	Completed						autopsy	prior to death? No 1 □ Yes	utopsy findings available completion of cause of
VITA VITA		0	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2.6 eath (Check only one)		5 2 NO
	d is	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	er /	Home 5 ☐ Residen		icity)
0	ding Ph The After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	/ at k?	28d. Describe how	injury occurred	
<u> </u>		cati	2 Accident investigati	he			Yes 2 □No			
DIVISION		ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, str cify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	Hospital or 14 hours after Funeral Dit tely filled in	O	29a, Certifier 1 Certifying F	Physician: To the best of my kr	sowledge deet	h annument at the sta			(-)d -i	
	HOS FL	edicai	(Check only 2 Medical Exa	aminer: On the basis of examinand manner stated.	nation and/or in	vestigation, in my op	pinion, death occ	urred at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1801 20.11	N	29c. License		-	d. Date signed (Mon	th, Day, Year)
	7			X VIII		100	05994		Debkup	4 27, 200 /
4	+1		30. Name and address of lersor who	o complete cause of death (lite	em 23a) (Type,	Print) Svite	307	mingen	iter Mc	7115)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Recontrar's Sign	nature	fich		,	· · · · · · · · · · · · · · · · · · ·	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per fh 9871 9-27-07 vt.
State of Maryland? Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Sentember 21. 2007 Brown Eloyd /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner agnes Baltimore are 8. Date of Birth (Month, Day, Year)
Oct. 15, 1931 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Virginia Days Hours 1 **□** M 2 □ F Yrs. 75 Director 228-38-6532 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show notified at 1
▼Yes 2
No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be U.S.A. 21217 701 N. Arlington Ave. Apt 502 Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner. once. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 DNNo Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diamond Taxi 10thCab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Rosa Harris Peter Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walnut Lane Apt 204B Philadelphia James H. Brown/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount CrematorySept 26, 2007Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTIMORE, 21. Signature of Funeral Service Licensee MD 21213 23a. Part1. Enter the disease, or complications that cau ad the state. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 20 minte Cardiac Arrythmia /Medical Due to (or as a consequence f) Examiner Dehydration Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Monknown Renal Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 24 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Tes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD DEA BC99/6795 September 21, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Meghan

31. Date filed (Month, Day, Year)

Checkley

2007

SEP 27

the

Baltimore, Maryland 21215-0036

he law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Wilar Proceeds P.O. Box 68760,

900 South

32. gistrar's Signature

Cation

AUCHUE

Ballmore, maybrond

			1 - For State Registrar Amend #8 F	er FH G872	andand / Don	artment of He	nalth and l	Mental Hyg	Reg. No.	31052
ı	Physic		_ ,	Brevard	III			2. Date of Dea Month	Day Year	1.4
	/Medi Examíi		4a. Facility Name (If not institution, gi 4675 Spencer I	ve street and number)	T T T	4b. City, Town, or L Nanjen		Sept.	24, 200 4c. County of Dea	
	Funeral Director		577-56-0946		e (In yrs. last birthday 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign lountry)
	Maryland	tor	Usual Residence of Decedent 10a. State	.es	10c. City, Town or L Nat	ocation 1 j emoy				10d. Inside City Limits 1 X Yes 2 No
	th with the 23a or 28	al Direc	10e. Street and Number 4675 Spencer I	1.		10f. Zip Code 20662			10g. Citizen of What C	ountry?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be nutified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		
21215-0036	within 72 ho ane. then "netu	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4or 5	life.	dent's Usual Occupation of work done du DO NOT use retired)		rking	16b. Kind of Business Governme	
Maryland 2	12 should be filed within "h and Mental Hygiene." Fle marked other then "raumatic event, the Mac	To Be Co	17. Father's Name (First, Middle, Las John Breva			1			Maiden Sumame)	
	1 and 2 shou Health and M em 27 le mar		19a. Informant's Name/Relationship Annie L. Breva	(Type Print) rd/Wife	19b. Mail 4675	ng Address (Street an Spencer	nd Number or Ru	ral Route Numbe Nanjemo	r, City or Town, State,	Zip Code) 1662
Baltimore,	permit. Pages 1 a Department of He Important: If Item any Injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control o			matory or other place). Onal Cem			20c. Location - City o	ID
Ball	permit. Pa Departmer Important any Injury		21. Signature of Funeral Service Lice	alato	1	0583 Mid	ldlepor	t Lane	y lor II F White Pl	ains, MD
760, <	Physician /Medical Examiner per project is prujaj-itausi	Ical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence of):	ler the mode of dying,		or respiratory and	rest,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
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of Vital Records,		Completed						24a. Was a autop: perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
Vita	Physiclan: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:				th (Check only or	18)	
on of	ng Phys fter this neral di	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injui	y 28b. Time o	f 28c. Injury a Work?	4 - 14d13111g 11	ome 5 Resid	ence 6 Other (Spe ow injury occurred	ocity) HOSPU
Division	tel or Attendii s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	e One Blace of lais	ury - At home, farm, st c. (Specify)			28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b	edical	one) 2 Medical Exa	miner: On the best of miner: On the basis of and manner sta	examination and/or in	vestigation, in my opin	nion, death occur	rred at the time, d	late and place, and du	e to the cause(s)
	with To	2	29b. Signature and title of certifier	M	- e	29c. License r	9658	2	29d. Date signed (Mon	th, Day, Year)
	11		30. Name and address of person who J. Lee, MD 6104				le MD	20749		•
	Sta	te	31. Date filed (Month, Day, Year)	32. F gistra	ar's Signature	WETE HIT	. 13 / FID	20/30		
	Registr	ar	CED 2 7	2007 /	w K A	TO ALL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 25 2007 **Physician** 4:00 A. M Cluster Peggy F. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numberHealthcare Examiner Roland Park Place -Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | NOV 18, 1920 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Yrs. 86 Maryland 219-22-9664 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 X Yes 2 □ No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 + Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Fox Bertha Gordon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard B. Cluster, 33 Jackson Street Cambridge, MA son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 09/25/07 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-Stage ears **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes icate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? director, 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Vilatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physiclan: 24 hours after death. Funeral Director: / filled in within 24 hou

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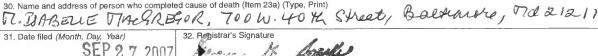
Registrar

31. Date filed (Month, Day, Year) SEP 27

29b. Signature and title of certifier

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(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D13657

29d. Date signed (Month, Day, Year)

Signifember 25, 2007

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				1 - State of Maryland 1 - State of Maryland 1 - Per FH G8/1 9/2/	707 JH Cer	tificate of Death			31054
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		/Medic	al	Harriet Grafton Case 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		4c. County of Death	9:45 P. M
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		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In		If Under 1 Year If Under 2 Months Days Hours			place (State or Foreign
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~	Maryland 21215-0036	12 sho h and 7 is m traum		19a. Informant's Name/Relationship <i>(Type, Print)</i> Mr. Edward Hickman Greene,II (Son	1	g Address (Street and Number			1
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		(aun	rteur		020)		O.C.N	1.E.		Septe	ember 21, 2	2007	
9		30. Name and address of person Laron Locke MD.	on who completed ca Assistant Medic	•		n Street,	Baltim	ore, MD 21.	201				
S: Regis	tate trar	-A 100 00 C		gistrar's Signatu	Tree A	asti)							

DHMH 17 Rev 1/2001 OCME 2006

hristian Freder		1- For State	•	nt of Health and Menta <i>te of Death</i>		No. 2007 3105
Physici		Registrar 1. Decedent's Name (First, Middle,Last)	rederick Gordon Chr	ristian, Jr.	2. Date of Death	3. Time of Death
ledical Exami	iner.	Frederick Cor			Month September	
		4a. Facility Name (if not institution, give stree Northwest Hospital E.R.	t and number)	4b. City, Town, or Location of Randallstown	Death .	4c. County of Death Baltimore County
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd			(MM/DD/YYYY) 9. Birthplace (State or
Director		215-88-8268 XX _M	2_F 46	Yrs. Months Days Hours	July	9,1961 Foreign Maryland
any	w 1 m	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
*	_	MD Baltimor	,	gs Mills		1 Yes 2 No
darylar 28a-f s Laton	Director	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Country?
h the N 3a or		218 Midpines Cou		21117	. 95	U.S.A.
death with the Maryland or items 23a or 28a-f shu	Funeral		Armed Forces?	 Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 		14. Race - American Indian, Black, White, etc.
after de	/ Fu	3 Widowed XX Divorced If Yes,	Yes 2XXNo Give Year	1 Yes XX No specify:	1.0	Specify: White
ours a	d by	15. Decedent's Education (Specify only high	hest grade completed) 16a. De	ecedent's Usual Occupation (Give ki		16b. Kind of Business/Industry
36 thin 72 h e. than "n	plete	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	Home Builde		Construction
5-0036 iled within 72 Hygiene. I other than the Medical	Completed	17. Father's Name (First, Middle, Last)			s Name (First, Middle, M	
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Be (Frederick Gord			ith A. Su	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Medical Hygiene. Important: If frem 27 is marked other than " injury or other traumatic event, the Medical I	2	19a. Informant's Name/Relationship (Type, PAmy O'Connell /		Mailing Address (Street and Numb		
e, MD 2 1 and 2 shou Health and I item 27 is r	s 30	20a. Method of Disposition	20b. Place of I	Disposition (Name of cemetery,	Date Date	t.2A Owings Mills Maryland 2111 20c. Location - City of Town, State
altimore, mit. Pages 1 an partment of Hee portant: If ite lury or other tr.		1 Burial 2XXCremation 3 Re 4 Donation 5 Other Specific	Milovai irom otate	y or other place) Crematory Inc.	9/27/07	Baltimore, MD
Baltir permit. I Departme Importar	-	21. Signature of Furieral Service Ligensee	130020			Suneral Chapel P.A.
		- Rebad June				Owings Mills, MD211
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	€.	enter the mode of dying, such as ca	ardiac or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death
caminer		and and a second	caine intoxication (or as a consequence of):	-	•	Deam
	_	Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence of):	·	• 11 - 5.7	5105, 19
ed sit	Exar	events resulting in death) Last Due to	o (or as a consequence of):			
execut an and al - tran		X UNPENDED X AM	ENDED OF OO S			
Accords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans		IF FEMALE: 230	1,23a,2/,28a-f, per c. If yes, outcome of pregnancy	ME,g872, 10/2/07 TT		23d. Date of delivery
30x 6876 leath certificat e attending ph for use as the	ian/	23b. Was decedent pregnant in the past 12 months?	Live birth 2		pregnancy	Month Day Year
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown 9	Unknown	Other (Specify)		
o.O. that the ed by t	by Phy	Part II. Other significant conditions contr	ibuting to death but not resulting in	in the underlying cause given in Par		bacco use contribute to the cause of death?
Is, P.C quires that en signed ald be deta					1Yes I 24a. Was a	2 No 3 Probably 4 ✔ Unknown 1 24b. Were autopsy findings available
Records, The law required for the law been since th	Completed				autops perfor	sy prior to completion of cause of
		OF Man and referred to medical.		OC Diagraph Death (2 No 1 Yes 2 No
Vital hysician: this certi) Be	25. Was case referred to medical examiner? 1 Yes 2 No	al: 1 Inpatient 2 V ER/Outp	26.Place of Death (patient 3 DOA Other		Residence 6 Other:
of \ng Phy	n: To	27. Manner of Death	8a. Date of Injury (Month, Day, Year) 28b. Tir	me of Injury 28c. Injury at Work?	? 28d. Describe h	ow injury occurred
ttendi death.	aţio	Natural 5 Pending Accident Investigation		3:40 am 1 Yes 2 X	No unk -	
Division tal or Attendi rs after death. at Director: /	Certification:	Suicide O A Could not be		m, street, factory, office building, etc		treet and Number or Rural Route Number, City late) INES Ct. 2A Owings Mills, M
Division of Vital Hospital or Attending Physician: 24 hours after death: Femeral Director: After this certifi ety filled in by the funeral director,		29a. Certifier	(Specify) found at home	ne occurred at the time, date and place		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Examiner:On the		restigation, in my opinion, death occ		
F.≱F.8	Me	29b. Signature and title of certifier	C .	29c. License number		29d. Date signed (Month, Day, Year)
		Patricia aron	ica-tollaka	O.C.M.E.		September 23, 2007
TO		30. Name and address of person who complete Patricia Aronica-Pollak MD.	eted cause of death (Item 23a) Assistant Medical Examir	ner 111 Penn Street, Bal	Itimore MD 21201	
U '	tate	31. Date filed (Month, Day, Year)			IUITOTE, IVID 21201	
Regis		SFP 2. 7. 200	17 Blen &	porte		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 24, 2007 **Physician** 2:00 p M Clark Donald G. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner n/a 3540 Woodring Avenue Baltimore 8. Date of Birth
(Month, Day, Ye 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) ^{Year)} 1932 **Funeral** Months Days Ohio 219-28-1021 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Y Yes 2 □ No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. 3540 Woodring Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 X Yes 2 No 151 - 154 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Letter Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clark Louisa Not known 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3540 Woodring Ave., Baltimore, MD 21234 19a. Informant's Name/Relationship (Type. Print) 3540 Woodring Ave., Baltimore, MD Donna L. Clark-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/07 Towson, MD Hilltop Srv Corp 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee William G. Dau Baltimore, MD 5305 Harford Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence Division or Vital Records, P.O. Box 68760, physician the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions conditioning to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed Hospital or Attending Physician: 25. Was case referred to polical examiner? funeral director, 26. Place of Death (Check only one). Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 He tural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 < Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number

State Registrar Name and

31. Date Med (Month, Day,

Year)

DHMH 17 Rev 1/2001

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb /8874 12-28-07 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** in wood EFFENBER 21,200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3507 Springdale Avenue n/a Baltimore 5. Social Security Num If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–31–1943 Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 63 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at t E Yes 2 □ No Director Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3507 Springdale Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 10 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No African-American Completed by 3 ☐ Widowed 4 X Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Federal Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Linwood H. Boyd Bertha Clark P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin F. Clark/Son 41 Saddlestone Crt. Owings Mills, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 9-29-07 Woodlawn, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Tylie F/ II F.A. of Paltimore County 21. Sign by e of Funeral/Service Licens 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ra nam /Medical (or as a consequence of): Examiner riphic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 = 12 Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 1□ Yes 2 100 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check on one) and manner stated. within 2 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print 30. Name and address 37,2 Strut # 136 31. Date filed (Month, Day, Year) State Registrar

LINGORD

William Dven 07-07412

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		State 1- For State Registrar	e of Maryland /		artment of rtificate of		d Mental		teg. No.	007 3104		
Physici Medical Exami		Decedent's Name (First, Middle,L	William	D. [Diven, S	Jr.		2. Date of Dea		3. Time of Death 1815 hrs		
		4a. Facility Name (if not institution, g 1600 block of 41st Stree			•	b. City, Town, or Baltimore	Location of De		4c. County of N/A	Death		
Funeral Director		213-86-0547		(In yrs. i.	last birthday) Yrs	If Under 1 Yea Months Days		1.6	rth(MM/DD/YYYY)	9. Birthplace (State or Foreign Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County	1	0c. City.	, Town or Locati	on				10d. Inside City Limits		
*	ō	MD N	/A		Baltin					1XX Yes 2 No		
the Mary 3a or 28a-	Director	10e. Street and Number 1435 Roland Hei	ghts Avenue			10f. Zip Code 2121	1		10g. Citizen of Wha	•		
s after death with the Maryland ral", or items 23a or 28a-f shu ther must be notified at once	by Funeral		XX Yes 2 ed If Yes, Give Year or Dates:	No	If Y	es, specify Cuban	, Mexican, Pu specify:		White,	White		
5-0036 led within 72 hours after itygiene other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5-			t's Usual Occupat ost of working life. Lter						
21215-0036 nuld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, La William D. Dive	en, Sr.				Helen	ame (First, Middle, F. Herli	ine			
MD 2 d 2 shouldth and M in 27 is m aumatice	2	19a. Informant's Name/Relationship Robert Diven (B	(Type, Print) rother)					or Rural Route Nur Y Balto,	mber, City or Town, MD 212.			
or Hear tra		20a. Method of Disposition 1 Burial 2 X remation 3 4 Donation 5 Other Species	Removal from State	.1 (ition (Name of cer		Date 09/27/07	20c. Location - C	Oity or Town, State Ville, MD		
Baltimo permit. Page Department Important: injury or ot	-	21. Signature of Funeral Service at Cansee 22. Name and Address of Facility Burgee-Henss-Se 3631 Falls Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca						tz Funera Balto,	l Home MD 2121	Inc.		
Physician /Medical: caminer		failure. List only one cause on	notications that caused the each line. a. Blunt and Sharp Due to (or as a consequence)	Force	Head Injurie		such as cardi	ac or respiratory an	rest, shock, or hear	Approximate Interval Between Onset and Death		
Sit at	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)			d						
be executed sician and burial - transi	edical	UNPENDED	dAMENDED						- 			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burial	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown		2 Fet	al death 3 [ner (Specify)	Ectopic pre	egnancy	23d. Date of di Month	elivery Day Year		
ires that the signed by the detache	by Phy	Part II. Other significant conditions	contributing to death I	out not re	esulting in the u	nderlying cause g	iven in Part I.			ute to the cause of death? Probably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed								osy pri- ormed? de:	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2	ER/Outpatient		of Death (Che	eck only one)	Residence 6 ✓	Other: Scene		
ion of \ tending Phy eath. for: After the	\vdash	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND:		28b. Time of Ir FOUND: 1800 hrs	njury 28c. Injur	y at Work? es 2 🗸 No		how injury occurred			
Divisior Hospital or Attenc 24 hours after death Funeral Director:	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	t be 28e. Place of Inju	-	ome, farm, stree	t, factory, office b	uilding, etc.	or Town, S		or Rural Route Number, City		
To the Hospital within 24 hours. To the Funeral completely filled	Medical C		cian: To the best of my ler:On the basis of exami									
F 3 F 3	ğ	29b. Signature and title of certifier	and low	7		29c. License O.C.N			29d. Date signed September 2	(Month, Day, Year) 23, 2007		
4		30. Name and address of berson who	completed dause of dea Assistant Medical E			enn Street, B	altimore, N	MD 21201				
St: Regist	State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature											

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07195 State of Maryland / Department of Health and Mental Hygiene Bryan Clinton Duvall Edwards, Jr. 1- For State Certificate of Death Registrar 2. Date of Death I. Decedent's Name (First, Middle,Last) Physician/ September 16, 2007 0559 hrs Medical Examiner

Bryan Clinton Duvall Edwards

4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD Months Days 218-21-2133 1988 Oct. 28. Director 18 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 1 Yes 2 X No Glen Burnie Anne Arundel 28a-f show MDDirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7834 Park West Drive Apt. 201 21061 U.S.A. with the 23a o notifi 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status

1 Never Married traumatic event, the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married Yes Specify: Black 9 Yes 2 X No specify: Divorce If Yes, Give Year Widowed item 27 is marked other than "natural", <u>ج</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed timore, MD 21215-0036

t. Pages I and 2 should be filed within 72 ht timent of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Student N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brvan Clinton Duvall Edwards, Sr. Jenny Bush Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7834 Park West Drive Apt 201 Glen Burnie MD 21061 Jenny Bush/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, MD Veteran Cemetery Garrison Forest tment of H rtant: If it y or other I 1 X Burial 2 Removal from State Cremation 9-27-2007 Owings Mills, MD Donation 5 Other Specify: Ambrose runeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 Signature of Fufleral Service Licensee Approximate Interval Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I, Enter the diseas complications that caused the death. **Physician** Between Onset and failure. List only one cause on each line. Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical **AMENDED** attending physician or use as the burial -UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. P contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ No 3 Probably 4 ✔ Unknown Completed Records. 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy performed' death? 1 🗸 Yes certificate h ector, page ✓ Yes 2 26 Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this ဥ 1 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death

To the Hospital or Attending Physician: within 24 hours after death. Division of Vital After Medical Certification: Director: d in by the f To the Funeral

28a. Date of Injury (Month, Day Year) Sep 16, 2007 Subject shot in vehicle 0500 hrs Natural Yes 2 V No Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 8237 Dunfield Court, Severn, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29c. License number 29b. Signature and title of certifier OCME O.C.M.E.

30. Name and address of person who completed caule of death Assistant Medical Examiner Theodore M. King, Jr., MD.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 17, 2007

State Registra

2

3

31. Date filed (Month Day Yea)

			1 - For State Registrar	State of Maryla		artment of <i>rtificate o</i>		Mental Hy	/giene 0	07	310	63
	Physic	an	Decedent's Name (First, Middle, Las	t)			LL	2. Date of D Month		Year	3. Time of	Death
	/Medi		Doyle			Evere	TT	Septem		2007	350	ДМ
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		0	, or Location of Dea	ith .	4c. Count	y of Death		
-	Funcial		The Johns Hopkin 5. Social Security Number 6. Se		. last birthday)	If Under 1 Ye	ar If Under 24 Hr	s. 8. Date of B	idh	9 Rirtho	ace (State o	r Foreign
	Funeral Director	3		M 2□F 4	49 Yrs.	Months Day			ay, Year	Coun	MD	r roreign
	rylanc show		10a. State 10b. County		ity, Town or Lo					11	d. Inside Cit	-
	r 28e-f show	Director	MD		Baltir						1 XYes	2 🗆 No
	th with 230 o	al Dire	10e. Street and Number 3106 Weave	er Ave		10f. Zip Code	21214		10g. Citizen of	What Coun	try?	
36	atter or ite	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Control of Yes 2 ▼ N	f Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or N rto Rican, etc.)	1	ce - America ck, White, of fy: Bla	etc.	
21215-0036	72 hours "natural", edicul Exa	ted	15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occ	supation		16b. Kind of E	Business/Inc	ustry	
21	C 2 2	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of we ired)	orking			- /	
	be filed within tal Hygiene. Id other then event, it is M		12 Esthada Nama /First Middle / asth	2	•	Secur			600		rent	
Maryland	Q to 20 0	To Be		verett			EVYC	nme (First, Middle	e Ree	ele		
Mai			Gail Everett /	ype, Print) SPOUSE			et and Number or F					
	is 1 and of Health itam 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	Ave. E	Date Date	20c. Location	· City or To	vn, State	
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	removal from State	ournotory, crar	natory or other p le Park	lace)	26,200	River	dale	MA	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatur o Funeral Service Licens		A. 22	Name and Add	ress of Facility	neral C	Chaple	cotor ?	Y 20	3011
			23a. Part1. Enter the disease, or compishock, or heart failure. List only o	lications that caused the dea	th. Do not ent	er the mode of d	ying, such as cardia	c or respiratory a	arrest,	4/08) 1	Approximate Interval Betw	4
	Physician		Immediate Cause (Final disease or condition	Sepsis							Onset and D	
4	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						- J.y	2
	Lxammer	ē	Sequentially list conditions,	b. Ischen		ovel					y gus	(5)
	nted I Insit	mlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (or as a conser	quanted oi).							
ó	execu in and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
8760,	cate be executed obysician and the burial-transit	dlcal	L.	d								
89)	artifica ing ph e as th	Med	IF FEMALE:	-								
P.O. Box	The law requires that the death certific site has been signed by the atlending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous policy co	aldeath 3□	Ectopic pregnan Other <i>(specify)</i>	ocy		I .	ite of deliver onth i		ear
٩	uires that the di signed by the d be detached	by Ph	Part II. Dther significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cause g	given in Part I.	23e. Did	tobacco use con	tribute to the	cause of de	eath?
of Vital Records,	w requires been sig should be	ed b						1 🗆	Yes 2 No	3 🗌 Proba	bly 4 ∏Uı	nknown
ဝ၁	ie law requ has been je 2 shouk	Completed						24a. Was	an 24b.	Were autop	sy findings a	vailable
Ä	ysician: The is certiticate he director, page	E						auto perfo	ormed?	death?	pletion of ca 2□ No	use of
/ita	Physician: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath Check on				
of	Physi this o	2	1 195 2 2 2 100	and the second second second second	ER/Outpatien	3 DON		Home 5 Resi				
5	e la	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		uryat ork? ⊒Yes 2.⊒No	28d. Describe	how injury occur	red		
Division	l or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, stre			28f. Location (Street and Numb	er or Rurai	Route Numb	er.
ā	el or	Certification:	4 Homicide determined	building, etc. (Specif	(y)	,,		City or To	wn, State)			
	To the Hospitel or At within 24 hours after or To the Funaral Direct completely filled in by	Medical (29a. Certifier 1 ← Certifying Physical Control only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and madate and place,	anner as sta and due to	ted. he cause(s)	
	To the within To the Comp	Me	29b. Signature and title of certifier		 -	29c. Licer	nse number		29d. Date signe	d (Month, D	ay, Year)	
	9		Daniel M	lunoz, Medical	Docto	- RES	-000		Septembe	r 21	200	+
0	γ										1	
l			Daniel Munoz, The	Johns Harkins	Hospita	1,600	North Wel	fe Stree	t, Baltin	nove Mar	yhad	21287
	Sta Registra	.e	31. Date filed (Month, Day, Year) SEP 2. 7. 20	32. Hagistrar's Signa	St A	and I						

			_ FOI	ate of Maryland	-			/lental Hy	giene		
			1 - State Registrar		Cer	tificate of I	Death		Reg. No. 2	07	31061
7	Physici /Medic		1. Decedent's Name (First, Middle, Last) Andrew Bryan	Filicko				2. Date of Dea Month Septemi	ber 24,	Ž007	9:12 a M
)	Examin		4a. Facility Name (If not institution, give street	·		4b. City, Town, or	Location of Death		4c. County		
2	3.0		1333 Wildwood Beach 5. Social Security Number 6. Sex	Road 7. Age (In yrs. Ia	st hirthday)	Esse	If Under 24 Hrs.	8. Date of Birt	h I	timor	Ce lace (State or Foreign
Ŀ	Funeral Director		169-24-8164 ¹□X™			Months Days	Hours Min.	June 26,	7, Year) 1933	Coun	sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	Maryl -f sho fied a	tor	MD Baltimore	e E	ssex						1 □ Yes 2 X No
	th the or 28a or 018	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	itry?
	s 23a o nust b	Funeral Director	1333 Wildwood Beach		10.11	21221			U.S.		
336	72 hours after death with the Maryland "natural", or items 23a or 28a-f show kdical Examiner must be notified at	þ	1 Never Married 2 Married 1	/as Decedent Ever in U.S rmed Forces? □Yes 2☎ No Yes, Give ear or Dates:	If	vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - America ck, White, o	etc.
5-0036		sted	15. Decedent's Education (Specify only highest grade con		16a. Deced	ent's Usual Occup	ation during most of work	ring I	16b. Kind of Bu	usiness/Inc	dustry
121	filed within 72 Hygiene. Ither than "na Ither the Medic	Completed		ollege (1-4or 5+)		ness Owne	during most of work	ang .	Indust	rial	Hoses
2	be filed that Hygis of other event, the	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnan	ne)	
ylan	should be and Mental marked o	To B	Andrew	Filicko			Rose	e	P	ratti	Ĺ
, Maryland	12 ha 7 is		19a. Informant's Name/Relationship (Type. F Jennifer Busch-daugh	· '			and Number or Rui ve., Bel				Code)
ore	8 2 = 5		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remove			sition (Name of natory or other place		Date	20c. Location -	,	,
Baltimore,	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1,	⊣ Gar Villiam G. D		of Faith	ss of Facility Led	8/07	Overle	,)
n	Depril Impo		Ma	IIIIam G. D	au 53	305 Harfo	rd Rd., E	Baltimor	e, MD	21214	ļ.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ns that caused the death. use on each line. Due to (or as a conseque	ite	er the mode of dyin		or respiratory ar	rest,		Approximate Interval Between Onset and Death
7	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
J	xecute and Il-trans	Examiner	that initiated events c	Due to (or as a conseque	ence of):		-qu				
8/00,	ficate be executed physician and s the burial-transit	dical	d	` .	,						
O. BOX 68	death certi e attending d for use a	Physician/Medi	in the past 12 months?	yes, outcome pf pregnan □Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown	death 3□	Ectopic pregnancy Other (specify)	,		23d. Dai	te of delive	ery Day Year
ds, r	requires that the een signed by the	by	Part II. Other significant conditions contributions Abdom. Lal As		ting in the un	, 0	en in Part I.				ne cause of death?
Vital Records,	2 53 23	Completed	Mydroneph	, rosis 01	4	4 Queys		24a. Was autop	rmed?//	death?	psy findings available mpletion of cause of
<u>a</u>	ian:	Be C	25. Was case referred to medical examiner?				26. Place of Deat			1 ☐ Yes	2 NO
0 0	hysic this ce al direc	To	1 ☐ Yes 2 ☐ No Hospit	1 Inpatient 2 E	R/Outpatient		4 Li Nursing Ho	ome 5 Resid	dence 6 □Oth	er (Specify	v)
	ding F	ion:	1 ☑ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	yat <br Yes 2∐No	28d. Describe h	now injury occuri	red	
DIVISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	o□ Could not be	e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre		163 2 110	28f. Location (S City or Tow	Street and Numb vn, State)	er or Rura	I Route Number,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner:	a: To the best of my know On the basis of examination	ledge, death on and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the orred at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	vithir To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signer	d (Month, i	Day, Year)
	/		I Bred D. Un.		>		34608			2510	
	15		30. Name and address of person who comple Brad D. Lerner	ed cause of death (Item 2	23a) (Type, F	Print)	ent 5t.	Suite	600	Balt.	o, MD 21218
	Sta		31. Date filed (Month, Day, Year)	32. gistrar's Signatu	ire	and?				-	
	Registr	ar	SEP 2 7 2007	parties h	r 150						

DHMH 17 Rev 1/2001

07-07495 Marvin Earl Gilewski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	1- For State Registrar Certifica	ate of Death	Reg. No. 2 Date of Death	7 3 0 6
Physician Medical Examine			Month Day Year September 24, 2007	2213 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
	Johns Hopkins Bayview Medical Center	Baltimore		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		. 8. Date of Birth(MM/DD/YYYY) 9. Birth Foreign	1
Director	556-19-1931 1x M 2 F 42	Yrs. Months Days Hours Min.	JUL 16 1965 Cou	ntry) KY
	Usual Residence of Decedent			10d. Inside City Limits
w any	10a, State 10b, County 10c, City, Town of			1 Yes 2 X No
Aaryland 28a-f show	MD Baltimore Dundal	10f. Zip Code	10g. Citizen of What Count	
th the Maryland 23a or 28a-f sho notified at once.		·		y.
ith the N 33a or notified		21222 13. Was Decedent of Hispanic Origin? (Sp	uSA pecify Yes or No- 14. Race - Americ	an Indian, Black.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shounstic event, the Medical Examiner must be notified at once	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
fred T., or		1 Yes 2 X No specify:	Specify: Wh	ite
ours a atura xamin	15. Decedent's Education (Specify only highest grade completed) 16a. D	Decedent's Usual Occupation (Give kind of videring most of working life, DO NOT use reti		ndustry
6 na 72 h	Elementary/Secondary (0-12) College (1-4 or 5+)	ů ů		
5-0036 Its and the property of		Groundsman	Landscapii (First, Middle, Maiden Surname)	ng
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica	17. Father's Name (First, Middle, Last) Myron Gilewski	Nelta	Emily Blanton	
ould be d Ments s mark tic even		Mailing Address (Street and Number or F	-	Zip Code)
MD id 2 should the and an 27 is 18 should the and an 27 is 18 should the annuality and an annuality an annuality and an annuality and an annuality and an annuality an annuality and an annuality and an annuality and an annuality an annuality and an annuality and an annuality and an annuality an annuality and an annuality and an annuality and an annuality an annuality and an annuality an annuality and annuality and annuality and annuality and annuality annuality and annuality annuality annuality annuality annuali	Kathi Prechtel - sister 61	11 Beecher Street, L	ouisville, KY 4021	15
		of Disposition (Name of cemetery, party or other place)	Date 20c. Location - City or	Town, State
MOF Pages nent of unt: If	Motro	Crematory, Inc. 9/2	7/2007 Baltimore	e. MD
Baltimore, permit Pages I ar Department of Her Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Steven H. Williams	22. Name and Address of Facility	10000	
m F g E ii	1 de la companya della companya della companya de la companya della companya dell	299 Frederick Ro	y of Maryland, Inc. ad, Baltimore, MD	
Physician / /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	t enter the mode of dying, such as cardiac o	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
caminer		and occaine and alcohol n	90	Death
**	or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted nisit	cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death.) Last Due to (or as a consequence of):			
d d ansit				
760, cate be executed physician and he burial - transit	X UNPENDED AMENDED #23a,27,28a-f, perly IF FEMALE: 23c. If yes, outcome of pregnancy	© -972 10/2/07 mm		
60, ate be	if FEMALE: 23c. If yes, outcome of pregnancy	E,g0/2, 10/2/0/11	23d. Date of delivery	
ox 687 eath certifics attending pl	23b. Was decedent pregnant in the past 12 months?		ancy Month D	ay Year
Box 687 e death certific the attending p ed for use as th	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting	Other (Specify)		
that the d		in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Division of Vital Records, P.O. ta or Attending Physician: The law requires that the reach ceath. The Invector: After this certificate has been signed by let in by the funeral director, page 2 should be detacted the control of the funeral director, page 2 should be detacted the control of the funeral director, page 2 should be detacted the formal of	AG .		1 Yes 2 No 3 Prob	ably 4 🗸 Unknown
ords, For requires s been sign should be				topsy findings available ompletion of cause of
e law			performed? death?	
tal Rections: The certificate ector, page		26.Place of Death (Check		2 10
Vital Rechysician: The Ithis certificate Idirector, page	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other Nursin	ng Home 5 Residence 6 Other	14 4
ion of tending Ph; eath. tor: After the funeral	27 Manner of Death 28h 28h 28h 28h 3	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion fendii eath. tor: /	Pending Fnd 9/24/2007 Fnd Part Investigation	d 9:15 pm 1 Yes 2 X No	unk	
Division At pita or At ours after of tilled in by	3 Suicide 6 X Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Hospita 24 hours a Funeral tely fille	3	ily residence	2004 Tarkhall Rd. Dund	,
		ath occurred at the time, date and place, and overstigation, in my opinion, death occurred	d due to the cause(s) and manner as state at the time, date and place, and due to the	ed. e cause(s)
To the within 2 To the complet	(Check only 1 Certifying Physician: To the best of my knowledge, decore) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
	Call AO KO O O	O.C.M.E.	September 25, 2	
	aroe Hellan			
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD 2120	01	
Stat	21 Data filed (Manth Day Veer) 32 Perstar's Signature	(A) (I)	-	
Registra	SEP 2 7 2007	1		

OCME

			Ancycl #20b per FH C872 10/05/07 JH Department of Health and M Certificate of Death	ental Hygie	ene . No. 2007	31066
**	Physici /Medic		1. Decedent's Name (First, Middle, Last) CATHERINE W. GRAY	2. Date of Death Month	Day Year	3. Time of Death 10: かりM
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number) BON Secours Hospital 5. Social Security Number 1 M 2 F 7. Age (In yrs. last birthday) Visual Residence of Decedent 4b. City, Town, or Location of Death But More 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Y	4c. County of Death	ace (State or Foreign try)
	e Maryland a-f show iffied at	ctor	10a. State 10b. County / A 10c. City, Town or Location Raitimore		10	0d. Inside City Limits 1 XYes 2 ☐ No
	ath with the 23a or 28 ust be not	Funeral Director	827 N. Arlington Ave \$503 21217	10g	Citizen of What Count	try?
9036	ours after dearing in a line in the merical in the merical in the merical in a line in the merical in the meric	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No Specify: 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		ib. Kind of Business/Ind	ustry U Service
Maryland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name Vira	(First, Middle, Ma	iden Surname) Walk	er
	1 and 2 sho Health and em 27 Is mother traums		19a. Informant's Name/Relationship (Type. Print) (Caretaker- 19b. Mailing Address (Street and Number or Rule Mrs. Mildred Cain 809 No Dukeland	St. Bo	ilto, Md.	21216
altimore,	permit. Pages 1 Department of H Important: If Iter any injury or ott		20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/0E	72007 2007	Scatton - City or To	wn, State
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Russ Fu		tome P.A.	6
100	Physician		23a. Party. Inter the dil/ ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of should on heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HOART		ure	Approximate Interval Between Onset and Death
4	/Medical Examiner	7.	Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):			
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
	ificate be executed j physician and ss the burial-transit	edical	d			
P.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pregnancy 5 □ Other (specify) □ □ □ Unknown		23d. Date of delive Month	ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to th	\
		Completed		24a. Was an autopsy performe 1 Yes 2	prior to con	osy findings available inpletion of cause of
Vita	siciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Thipatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hot		- 0 Dott (0*	
Division or	iding Phys h. : After this funeral dir	tion: To	The Market Service of	28d. Describe how	ce 6 ☐Other (Specify injury occurred)
DIVIS	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suisido 6 Could not be	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	he Hospit in 24 hours he Funera pletely fille	Medical (29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cau ed at the time, dat	se(s) and manner as st e and place, and due to	ated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier 29c. License number 241430	29d	Date signed (Month, L	Day, Year)
5	} \		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7001 Joint DR EDWARD OBAZEE WINDSOR MILE	INT CF	*KE (2)	44
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2007 32. Restrar's Signature			

DHMH 17 Rev 1/2001

			1 - State of Ma Registrar	-	artment of Health and Natificate of Death		0.2007 31067
	Physicia	_	Decedent's Name (First, Middle, Last) Katherine Ir	ene Good	man	2. Date of Death Month Seni- 20	Oay Year 4.30 AM
	/Medic Examin	105	4a. Facility Name (If not institution, give street and number) Fairhaven Nursing		4b. City. Town, or Location of Death		4c. County of Death Carroll
	Funeral Director			(In yrs. last birthday) 91 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea January 18	9. Birthplace (State or Foreign Country) West Virginia
	το		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	e Maryl 3a-f sho tiffed a	Director	Maryland Carroll		Sykesville		1 □Yes 2 No
	ath with th 23a or 28 ust be no	ral Dire	10e. Street and Number 7300 Third Avenue		10f. Zip Code 21784	_	Citizen of What Country? U.S.A.
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Endred Forces? 1 □ Yes 2 □ Note If Yes, Give Year or Dates:	ver in U.S. 13. V	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. than "natul he Medical	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) homemaker	aing 16b.	Kind of Business/Industry at home
Maryland 2	eve of c	To Be Co	17. Father's Name (<i>First, Middle, Last</i>) James Richard Ashby Davi	s	18. Mother's Nam	e (First, Middle, Maid Maggie	en Surname) Lena Dasher
	# 2 ± g		19a. Informant's Name/Relationship (Type. Print) Ms. Barbara A. Goodman Date		ng Address <i>(Street and Number or Ru</i> 355401 Gatewater Court (ral Route Number, Cit Glen Burnie, Mi	y or Town, State, Zip Code) aryland 21060
Baltimore,			20a. Method of Disposition 1		awn Memorial Gardens	09/26/07	Location - City or Town, State Marriottsville, Maryland
Rail	permit. Page Department of Important: If any injury or once.	5 0	21. Signature of Funeral Stryice Liger See	110195	2. Name and Address of Facility Slack Funeral Hom 3871 Old Columbia	a Pike Ellicott C	
á.	Physician /Medical Examiner	S. 1	resulting in death)		er the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
7,09/89	be executed siclan and burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):			
O. Box 68/	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2⋈ No 9 □ Unknown	2 ☐ Fetal death 3 ☐	⊒Ectopic pregnancy]Other (<i>specify</i>)	- J	23d. Date of delivery Month Day Year
rds, P	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions contributing to death but Park in i Di		nderlying cause given in Part I.	23e. Did tobacc	couse contribute to the cause of death?
Vital Records,	The ate has page	Completed				24a. Was an autopsy performed 1∐ Yes 25	
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatien	nt 2 ☐ ER/Outpatien	Other:	th (Check only one)	0 TOther (0-14)
on or	ing After uner	-1	27. Manner of Death Natural 5 Pending (Month, Day) Accident investigation	y 28b. Time of		28d. Describe how in	e 6 □Other (Specify) njury occurred
DIVISION	al or Atter after deal I Director d in by the	Certification:	CDC	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state.	examination and/or in			
1	Tot withi	Ž	29b. Signature and title of certifier		29c. License number 04372	29d.	Date signed (Month, Day, Year)
	15		30. Name and address of person who completed cause of de	9 Ridy	Print) Pound No	estminis	ter MD 21157
	Sta Registr		31. Date filed (Month, Day, Year) 32. F Sistral SEP 2 7 2007	r's Signature	Barle .		

Baltin	permit. F
	Phys /Me Exa
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
	0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 7 31068 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Year **Physician** 9-21 AM 21 2007 Bernice Frances Holloway /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Good Samaritan Hospital Baltimore
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. Yrs 235-50-5495 80 Jan. 30 1927 **Director** PA Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. tnside City Limits 10a. State 77 is marked other than "natural", or Items 23s or 28a-f ehow traumatic avent, the Modical Examinar must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Calloway 21215 Funeral Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No th Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 al Hygiene. nore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12th Social Worker State of Virginia yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill nent of Health and Mental Hant: If Item 27 is marked other traumatic aven Otho Horton Bessie Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jolene Tyson-Daughter 5 Walden Place New Castle, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Important: If Its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Sept. 24, 07 Balto., MD 21. Simatu e of Funerat Service License 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart vilure. List only one cause on each line. Balto., Md Approximate Interval Between Onset and Death tmmediate Cause (Finat Sepsis Severe sician disease or condition resulting in death) dical Due to (or as a consequence of): in Jechon miner Track Orinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical tF FEMALE: 23c, tf yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 🗌 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acidoso 1 Yes 2 No 3 Probably 4 Unknown Peripheral vascular disease and 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I performed? 1 Yes 2 No Eschemia Umb this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c 1 ☐ Yes 2 ☑No 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Funeral 1 Crafifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ai kaw 21 2007 MD RES OOD 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) GOOD SAMARITAN HOSPITAL, BALTHMORE, M.D. TANKAJ KAW 32. Registrar's Signature 31. Date filed (Month. Day, Year) State SEP27

Registrar

2007

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Funera

n	1. Decedent's Nan	- 4 6	n 0	401	PAL						2. Date of De Month	eath [N 2 ()	Year	3. Time of	
al	4a. Facility Name	CORGE					4b City	Town, or	Legation	of Dogth	SEPT.		21,	2007 by of Death	3:30) I
er	FUTUREC							TPOI		or Death				rimori	F.	
	5. Social Security		6. Sex		7. Age (In yrs.	last birthda		r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi				olace (State o	r Foi
	218-28-		1 121 1	1 2□F	74	Yrs	·	Bayo	riodio		JAN. 3		933		MD	
	Usual Residence of 10a. State	10b. County	,		10c. Ci	ty, Town or	Location							1	10d. Inside Cit	ty Lir
ctor	MD	BAI	TIMO	RE	DUI	NDALK									1 X Yes	2
Director	10e. Street and Nu	umber					10f. Zip	Code				10g. (Citizen of	What Cour	ntry?	
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Funeral	11. Marital Status 1 ☐ Never Mar	ried 2⊟ Man		. Was Dece Armed Fo 1 ☐ Yes		I.S. 1	3. Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Oi in, Mexica	rigin? (Sp in, Puerto	ecify Yes or No Rican, etc.)	0-	Bla	ace - Americ ack, White,	etc.	
þ	3 ⊠ Widowed			If Yes, Giv Year or Da	/e		1 ☐ Yes	2 X No	Specify	:			Speci	ify: WHI	TE	
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To Be	GEORGE		,								ET W. N	•		,		
	19a. Informant's N	-		Print)		19b. Ma	ailing Address	S (Street a			al Route Numb		y or Towr	n, State, Zip	Code)	
3	PEGGY D	IROCCO/	SIST	ER					CH RI		OUNDALK	, M	D 2	1222		
	20a. Method of Dis	sposition	3 □Ren	noval from		Place of Dis cemetery, c	sposition (Nai crematory or o	me of other plac	e)		Date	20c.	Location	- City or To	own, State	
	4 ☐ Donation	5 Other (S	Specify)		G	ARDEN	S of F			09/26	5/2007	BA	LTIM	ORE, N	MD 212	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Evelyn Howard RS 2007 1550 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Augsburg Nursing Home Lochearn If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M Months New York Yrs 83 216-20-9281 1924 July 14, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Lochearn Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21207 6811 Campfield Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify Specify: 3XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools 4 years Teacher 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loretta Wortman William Staufenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Old Boxwood Lane Lutherville, MD 21093 19a. Informant's Name/Relationship (Type. Print) Pamela Boyer (friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 9-27-2007 Bayview Crematory Baltimore, MD 4 ☐ Donation 5. ☐ Other (Specify) ure o Funera 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Wayne Osterling 130 E. Fort Ave. Baltimore, MD 21230 ask, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diameic Colon cancor disease or condition Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an autopsy 1□ Yes 25 No 25. Was case referred to medica examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

death

72 hours after

filed withir Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any Injury or other traumatic event, th

Baltimore, Maryland 21215-0036

r 28a-f show notified at

7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed by

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Certification: To

Medical

and burial-tra attending physician for use as the buria by the signed t ate has bage 2 s certificate this

requires that the death certificate be executed

The law

or Attending Physician:

within 24 hours after death.

To the Funeral Director: Atter thi
completely filled in by the funeral

To the Hospital o within 24 hours aft To the Funeral Di

Box 68760,

P.O.

Division or Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

2**3** No

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Yes

27. Manner of Death

1 Matural

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

26. Place of Death (Check only one)

Other: April Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Injury at Work?

Keisterstaun

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MO

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

> D37473 use of death (Item 23a) (Type, Print)

> > 57.

28c.

25,2007

3

State Registrar

Jef ZilDel 31. Date filed (Month, Day, Year) SEP 2 7

30. Name and address of person who com

29b. Signature and title of certifier

2007

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

25 32 Registrar's Signature JA 28405 3

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day ER 6:27AM HUM SEPTEM BEX17. 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner COURS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ₹M 2 □ F unk 396-32-5139 Director Mar 8, 1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD Yes 2☐No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue Funeral 21229 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk "natural", or items edical Examiner m Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black þ 3 Widowed 4 Divorced or than "natura the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 27 is marked c traumatic ever မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 se of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state 21. Signature of Funeral Tryice Licensee Ren Id S. Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to far as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 2 s certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 10 1 Impatient 2 ☐ ER/Outpatient 3□ DOA . Date of Injury (Month, Day Year) 28b. Time of 27. Manner Death 28c. Injury at Work? : After t 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: completely filled in by the funeral within 24 hours after death To the Funeral Director; 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D003035 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) BON SECOURS 31. Date filed (Month, Day, SEP 2 2007

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HRUTKAY Day **Physician** STEVE September 20, 2007 8:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Villa Nursing & Rehab Baltimore Catonsville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fiction Country)
Feb. 22,1916 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 ★M 2 F Yrs. 191-07-1804 91 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10e. Street and Number 21228 USA 1 Kenwood Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Specify. ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Building 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Unknown Ferdinand Hrutkay ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and then the Health and 27 is Kathryn Bradford - Daughter 15 Tanglewood Road; Catonsville, MD 21228 Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 9-25-2007 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Juneral Service Licensee 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate har death? 1 ☐ Yes 2 ☐ No 2. No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ² this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified arkarac M.D 121649 BALTIMORE, MD 21229, Dr. S. BASKARAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens

Registrar

31. Date filed (Month, Day, Year)

SEP 2 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22, 20. 5:46AM Pauline Vinje Howard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ctr Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. 63 1/25/1944 218-42**-**0780 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7969 Phirne Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold R. Vinje Dorothy Ida Pumphrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7969 Phirne Rd E Mr Leo F Howard Jr/husband Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) MD Veterans Cemetery 9/25/2007 Crownsville 21. Signature of Funeral Service Licensee Singleton Funeral & Cremation M01364 1 2nd Ave SW Glen Burnie MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e w 0 Due to (or as a conse pence of): Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perforr 1∐ Yes 2

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event "bear once." **Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at show

ms 23a or 7

r than "natural", or items the Medical Examiner mu

filed within 72 hours after

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-transit physician the as ģ certificate has page 2 funeral director, hin 24 hours after death. the Funeral Director: After this

P.O. Box 68760

Records.

Division or Vital

Physician:

Hospital or Attending

Examine Physician/Medical ð Completed Be မ Certification:

1 ☐ Yes 2 No 1 Natural

29a. Certifier

(Check only one)

25. Was case referred to medical examiner? 27. Manner of Death

2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

1 ☐ Yes

28c. Injury at Work?

29c. License number

2 □ No

2 ER/Outpatient 3 DOA

28b. Time of

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Test Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2

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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

3altimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

Leon & Hwang, M.D. 32. Regitrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

1396 Piccard Drive, Rockville, Maryland

D45880

29d. Date signed (Month, Day, Year)

September 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17 per inf 8872 10-2-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Olive Winnifred Humble September 24, /Medical 2007 7:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wilson Health Care Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F 465-26-9053 87 Director Feb. 5, 1920 Kansas Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits r 28a-f show notified at 1**Y**Yes 2 □ No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 301 Russell Avenue, #129 20877 United States Je filed within , _______, stal Hygiene.
sed other than "natural", or flems 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Church marked other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebert Maxwell Robert Maxwell Humble Olive Bigelow Wygal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate Ann Bell/Niece 5125 Wickett Terrace, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium 4 □ Donation 5 □ Other (Specify) 28, 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acture to Prince **Physician** Lt ZWECKS /Medical Due to (or as a consequen / of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 22 Examine executed burial-tran Due to (or as a consequence of) Box 68760 physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy Mala performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending ithin 24 hours after death.

o the Funeral Director: A

ompletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 004115 und 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1046

32. Reistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of l		Mental Hy	/giene Reg. No 200	7 31077				
	Physici		1. Decedent's Name (First, Middle, La Frances V. Greans	,	gton			2. Date of D Month Septer	Day Yea Tiber 25, 20	M				
	Examir		4a. Facility Name (If not institution, gir		r)	4b. City, Town,	or Location of Dea		4c. County of De					
1			Collingswood Nurs 5. Social Security Number 6.		Age (In yrs. last birthday)	Rockvi		s. 8. Date of Bi	Montgom					
	Funeral Director			1□M 2\XF	88 Yrs.	Months Days				Birthplace (State or Foreign Country) ew York				
	yland iow at		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits				
	a-fst	ctor	Maryland Montgom	nery	Rockvil1	le				1 XX Yes 2 ☐ No				
	ath with the Marylan 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?				
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36	after c	by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	i?]No	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2X No		erto Rican, etc.)	Black, Wi					
21215-0036	72 hours "natural"; edical Exa	ed k	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	ss/Industry				
215	within 72 ene. than "nai	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4o	r 5+) (Give	kind of work done DO NOT use retire	e during most of w ed)	orking						
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Maryland	s 1 and 2 should be filed within 72 hr if Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, <u>the Medical</u>	To Be	17. Father's Name (First, Middle, Las. Michal Kuss	")			Johann		e, Maiden Surname) Available					
Jan	2 sho		19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	t and Number or F	Rural Route Numi	ber, City or Town, State	e, Zip Code)				
	1 and 2 Health a	-	Gerald J. Greaney 20a. Method of Disposition	/Son	20b. Place of Dispo	O Dufief	Drive,	North Po	tomac, MD 20c. Location - City	20878				
Baltimore,	Page ent o		1 XBurial 2 □ Cremation 3 E 4 □ Donation 5 □ Other (Speci		St. Char	matorý or other pla Les Cemete	29	tember, 2007	Pinelawn,	New York				
Balt	permit. I Departm Importar any Inju		21. Signature of Funeral Service Lice	nsee	M01346 R	2. Name and Addr lockville lockville	ess of FacilityRo , Inc. 3 , Mary1a	bert A. 00 West nd 20850	Pumphrey F Montgomery	uneral Home/ Avenue				
	Physician /Medical		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death) a. On											
	Examiner	j.	Sequentially list conditions,	b. Due to (or a	is a consequence of):	to Th	rive							
8760,	certificate be executed rding physician and ise as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	is a consequence of):									
687	physi	dical												
Box	he death certificate be executed the attending physician and thed for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	cy		23d. Date of o	lelivery Day Year				
ds, P.O.	The law requires that the death ate has been signed by the atter bage 2 should be detached for L	by Ph	Part II. Other significant conditions		but not resulting in the u	nderfying cause gi	ven in Part I.		tobacco use contribute Yes 2 k No 3 □	to the cause of death? Probably 4 □Unknown				
Ö	w requir been si should	letec						24a. Was						
al Records,		Comp						- auto	opsy prior to death 1 □ You					
or Vital	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Off	hor:	eath (Check only						
ō	this d	٦. ح	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of In	tient 2 ☐ ER/Outpatier jury 28b. Time o	II 3 DOA	4 Nursing		idence 6 Other (S)	pecify)				
ion	nding F tth. r: After e funera	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	Pay Year) Injury		rk?]Yes 2		,,					
Division	after des after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	Zoe. Place of it	njury - At home, farm, str etc. (Specify)	reet, factory, office			(Street and Number or wn, State)	Rural Route Number,				
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical C	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the bes miner: On the basis and manner s	at of my knowledge, deat of examination and/or in stated.	h occurred at the to vestigation, in my	ime, date and plac opinion, death oc	ce, and due to the curred at the time	e cause(s) and manner , date and place, and d	as stated. ue to the cause(s)				
	To the within To the Compl	Me	29b. Signature and title of certifier	7.	04.7	29c. Licens			29d. Date signed (Mg					
			1 355	>m	MD	Do	06243	?5	9/25/0	7				
6	8		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)	MD 208	50	SAYED	ELSAYYAD				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2	32. P gis	trar's Signature	inde								

07-07419 Earl Hagerty Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of De	eath	Reg.	No. 200	1 3101			
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Earl W. Hagerty		September 2	ay Year 22, 2007	3. Time of Death 2227 hrs			
			City, Town, or Location of Death hestertown		4c. County of Death Kent				
Funeral Director		207-26-3993 1X M 2 F 73 Yrs.	Under 1 Year If Under 24Hrs flonths Days Hours Min		9. Birtl 21,1934 Cou	1			
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	ō	Penn. n/a Concordy	ille			1 Yes 2 X No			
h the Mary 3a or 28a- ootified at	l Director	762 Baltimore Pike P.O. Box 468	f. Zip Code 19331	10g.	Citizen of What Coun	•			
	y Funeral	1 Never Married 2 X Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No specify:	Rican, etc.) White, etc.		an Indian, Black,			
hours a	ted by	during most o	sual Occupation (Give kind of v f working life. DO NOT use reti	vork done 16	6b. Kind of Business/Ir	ndustry			
5-0036 led within 72 hours after Hygiene. other than "natural" the Medical Examine.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12 yr's Insuranc	e Agency Owner		nce				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Earl F. Hagerty	18.Mother's Name	(First, Middle, Mai	den Surname) McCummi	ngs			
Z 2 9 2 3	Q 19a Informant's Name/Polationship (Typo Print)								
ore, sslan of Hea If ite		20a. Method of Disposition 20b. Place of Disposition X Burial 2 Cremation 3 Removal from State	lace)		0c. Location - City or				
.드 은 을 들 능	-		emorial Park 9		Glen Mill				
	I	faul L. Hartool J? Leon	ard J. Ruck. I	nc. 5305	Maryland 2 Harford	₹ d .			
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do not enter the mediate. List only one cause on each line. Immediate Cause (Final disease a. Hyperturbative Atherosclerotic Cardiova)		r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
	<u>l</u> e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
d d	Examiner	Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
an and	ledical E	d							
3760, ficate be g physicials the buria	≥	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
Box 687 The death certification is the attending and for use as the	Physician	past 12 months? 4 Pregnant at time of death 5 Other (eath 3 Ectopic pregna	ncy	Month D	ay Year			
D. Bc t the dea by the a		1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?			
S, P.O. Lires that the signed by d be detach	<u>(</u> 조			1 Yes	2 No 3 Proba	ably 4 🗸 Unknown			
cords, law requii	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of			
Vital Rechysician: The this certificate		25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2 ₩		2 No			
Vita hysicia this cer	Ď	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	1 Othoru		sidence 6 Other:				
Division of Vital Records, tat or Attending Physician: The law require as after death. al Director: After this certificate has been si the in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.	Certification: T	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred				
Division Hospital or Attent 24 hours after death Funeral Director:		3 Suicide 6 Could not be determined (Specify)	ctory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rur e)	al Route Number, City			
0	Medical C) and manner as state place, and due to the							
F > F 8	ž	and manner stated. 29b. Signature and title of certifier	F	9d. Date signed (Mon.	_				
		30. Name and address of person who completed cause of death (Item 23a)		September 24, 20					
20		Melissa Brassell, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD	21201					
Star Registra		SEP 2 7 2007 SEP 2 7 2007	1						

Physician /Medical Examiner

permit. Pages Department of Important: If it any Injury or o

Physician

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10a. State

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3altimore, Maryland 21215-0036

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Physician/Medical

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Certification:

31. Date filed (Month, Day, Year)

SEP 2 7 2007

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATITISC ONSESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 🔀 🕽 o 6 Other (Specify) HUSFICE 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1920 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) D64395 SEPTEMBER 26,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

DANIEUR DOBERMAN, MO 6565 N CHARLES ST, SUITE 209 BALTIMORE, MO 2124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 31080 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear 09:20 AM **Physician** Sentember JONES 22 2007 ANNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Battimore Washington Medical Glen Burnie center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 90 Yrs. NOV.10,1916 NORTHCAROLINA 217-76-3515 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. Count 10c. City. Town or Location **ehow** the Medical Examiner must be notified at 1X Yes 2 No MD. N/A BALTIMORE Director 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 204 S. CATHERINE ST. 21223 USA Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Heelth and Mental Hygiene. Item 27 is marked other then other traumatic event, the Mental Elementary/Secondary (0-12) College (1-4or 5+) 6 none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hinportant: If Item 27 is marked oth any linjury or other traumatic event one. Be JONNIE JONES NANCY PICKETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 242 WARFIELD RD. GLEN BURNIE, MD. 21060 ANN SMITH (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT.CALVARY CEM SEPT.27,2007 ANNE ARUNDEL CO. 22. Name and Address of Facility 21. Signature of Funeral Service Licansa CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 213 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Henat **Physician** Congestra /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tes this certificate 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. М 2 Accident the 3 🗍 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) WAShington Medical Center 32 egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			Please	e Type or Prir								
		For State Registrar		State of Ma	aryland / De	epartment of F Certificate of	Health and M	lental H	ygiene	2007	31081	
		Registrar 1. Decedent's Nam	no (First Middle I	(act)		pertificate of	Deain	2. Date of D	Reg. No.			
Physici		Mary Vir		,				Month	Day	22. 2007	3. Time of Death 11:12a M	
/Medic Examin		4a. Facility Name (i	If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	Deptell		County of Death	11:12a	
. <u>II. , e </u>	М	Stella M				Timonium				ltimore		
Funeral Director		5. Social Security N 219-20-9		Sex 7. Ag	e (In yrs. last birth 79 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth ay, Year)	9. Birthp	place (State or Foreign	
		Usual Residence o	f Decedent					Sept.	10, .	1920	MD	
lanylar show	Į.	10a. State	10b. County		10c. City, Town o	or Location	10d. Inside City Lim 1					
the N 28a-1 notiff	rect	MD 10e. Street and Nu	Baltimo mber	re	N/A	10f. Zip Code			10a Citiz	en of What Coun		
th with 23a ol Ist be	Funeral Director	1708 Rit	tenhouse	Avenue		21227		U.S.A.				
tems ter mu	uner	11. Marital Status		12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or N Rican, etc.)	or No- 14. Race - American Indian, C.) Black, White, etc.			
rs afte		1 ☐ Never Marr 3 ☐ Widowed	ried 2∏ Married 4 X Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2X No	Specify:			Specify: white		
7-0-1	Completed by	(Cno.	15. Decedent's	Education	16a. D	ecedent's Usual Occup	ation		16b. Kin	d of Business/Inc	dustry	
ithin 7	mple	Elementary/Seco		College (1-4or 5	+) (6/1	Give kind of work done if the DO NOT use retired	during most of worki d)	ing	A 8. I	& P Grocery		
Hygie Ther ti	S	12 17. Father's Name	(First Middle La	st)	<u> </u>	Baker	18 Mother's Name	/Eirst Middl		den Surname)		
ld be lental ked o ic eve	To Be	James Cl		*			Josephine	, ,		,		
and Manatament		19a. Informant's Na			19b. N	Mailing Address (Street	and Number or Rura	al Route Num	ber, City or	Town, State, Zip	Code)	
and and tealth m 27 her tra				tt/Daughter		8 Rittenhou						
partition of the property of the Maryland ALL 13-00000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If the AZ Is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 ☐ Burial 2	Cremation 3	☐Removal from State	West Ar	isposition (Name of crematory or other plac UNCEL Crema	e) atory 9-2	Date 5-2007		ation - City or To	•	
nit. Partme		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Specure Lice Service Lice Service Lice Service Lice Service Servic									
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		23a. Part1. Enter to shock, or hea	he disease, r o art failure. Li onl	mplications that c + ed ly one cause on each lin	the death. o not	enter the mode of dyin	ng, such as cardiac o	or respiratory	arrest,		Approximate Interval Between	
Physician /Medical		Immediate Cause (disease or conditio resulting in death)	(Final n	a. LUNG CA							Onset and Death	
Examiner				Due to (or as a	a consequence of)							
	ner	Sequentially list co if any, leading to in Cause (Disease or	nditions, nmediate	b. Due to (or as a	a consequence of)							
ecute and -trans	Examiner	Cause (Disease or that initiated events resulting in death) L	6	c								
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				Due to (or as a	a consequence of)							
tificate ig phy as the	Physician/Medical			d					1-			
eath certific attending p	an/N	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome p 1 ☐Live birth	of pregnancy 2 Fetal death	3 ☐Ectopic pregnancy	,		23	3d. Date of delive	,	
he dea the a	ysici	in the past 12 1 ☐ Yes 2 █ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify)				Month	Day Year	
that the de ned by the a		Part II. Other signif	ficant conditions	contributing to death bu	t not resulting in th	e underlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to th	ne cause of death?	
w requires been sign should be	ed by							1 🗆	Yes 2□] No 3 ☐ Prob	ably 4XTUnknown	
law re las be	Completed							24a. Was		24b. Were autop	psy findings available npletion of cause of	
10 ==								perf 1□ Yes	ormed? 2 💢 No	death? 1 ☐ Yes	•	
Attending Physician: rideath. ector: After this certifical by the funeral director, p	o Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpatier	at 2 DEB/Outpo	itient 3 DOA Othe	26. Place of Death					
ig Phy ter this	\vdash	27. Manner of Death	h	28a. Date of Injur (Month, Day	y 28b. Tim	e of 28c. Injun	4 □ Nursing Hor	ne 5∟Res 28d. Describe		Courred	O HOSPICE	
tendir eath. tor: Af the fur	catio	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not I	on	rour) Inju		Yes 2 □ No					
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		ry - At home, farm, . (Specify)	street, factory, office	2	28f. Location (City or To	Street and wn, State)	Number or Rural	l Route Number,	
		29a. Certifier	1 Certifying P	hysician: To the best o	f my knowledge, d	eath occurred at the tin	ne, date and place, a	and due to the	cause(s) a	and manner as st	ated.	
the Ho nin 24 the Fu	Medical	(Check only one)		aminer: On the basis of and manner sta	examination and/c ted.			ed at the time	, date and p	place, and due to	the cause(s)	
To Con	2	29b. Signature and	title of certifier			29c. License		_	29d. Date	signed (Month, L	Day, Year)	
.0	-	30 Name and addre	ass of narson who	completed cause of de	ath (Itam 23a) /Tu		5725		7	124/0	7	
10		DR. TARI		DD 2300 DUI	LANEY VAI	. ,	'IMONIUM,	MD 210	93			
Stat		31. Date filed (Mont		32. F	r's Signature	- NO -						
Registra			SEP27	ZUU/ Messe	G. S. S.	GRAEL!						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPTEMBER 24, PAUL A. JAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGES MAGNOLIA HOSPICE CENTER LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Months. Hours XXM 2□F 1-24-1917 US VIŘGIN ISLANI 90 Director 580-01-3713 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatth and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at PRINCE GEORGES LANHAM Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES VIRGIN 20769 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be 6900 GLEN DALE RD. Funeral 14. Race - American Indian, ISLAND 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify. Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMS -0-INSPECTOR -7-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REBECCA POLIDORE ALFONSE JAMES ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6900 GLEN DALE RD. LANHAM, MARYLAND 20769 MYRNA ROBERTS (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State permit. Page Department of Important: If any injury or once. CHRISTIANSTED CEMETERY 10-1-2007 ST. CROIX, VIRGIN ISLAND 21. Signature of Funeral Service LicenseeJONATHAN D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 mer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) asnivation **Physician** monia Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 ☐ Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cepha lopa 24a. Was an autopsy performed 1∐ Yes 2 1 Min 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOS DICE 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007

6:00M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Days

Day

29d. Date signed (Month, Day, Year)

Year

1 X Yes 2 □ No

State

DHMH 17 Rev 1/2001

within 24

QUEENSBURY Rd HYATTSILLE MD 2018)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person

4 ☐ Homicide

29a. Certifier

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2007 Buddy Gene Kozen 29 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Communuty Hospital Prince Georges Lanham 8. Date of Birth (Month, Day, Year) July 25 1943 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1☑M 2□F 234-66-4376 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Fernglen Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 f Yes, Give 2 No 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) System Analyst Contractor General Dynamics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Stephanie Kozen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lela Mae Kozen (Spouse) 201 Fernglen Avenue, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signalure Funeral Selvice Lite se 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one sause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic Pancreatitis disease or condition resulting in death) Due to (or as a consequence of): Atherosciencia Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Diabetes mellitus resulting in death) Last Due to (or as a consequence of): renal failure IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1

✓ Yes 2

No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner The law requires that the death certificate be executed Ø'09289 xoB P.O. I or Vital Records, Division Hospital or Attending

Examine and burial-t attending physician for use as the buria Physician/Medical the as ed by the a signed | Completed by page 2 s certificate : After this certification funeral director, Be 2 Medical Certification:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Hyglen Important: If item 27 is marked other than any lnjury or other traumatic montal.

Physician

Maryland 21215-0036

death. after death.

Director: / To the Hospital o within 24 hours aft To the Funeral Di completely filled in

29a. Certifier

29b. Signature and title of certifier

and Alemi

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCK ROAD LAWHAM, MO 8118 6000 ALEMU H.D.

32 Registrar's Signature

and manner stated

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ı	For State Registrar	State of Mai	•	Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 7 3 1 0 8 4									
			Decedent's Name (First, Middle, Last	st)						2. Date of De Month	ath Day	Year	3. Time of Death		
	Physici /Medio		Baby Boy Kerney							Septer		20,200			
	Examin		4a. Facility Name (If not institution, give	street and number)	11	4b. City	, Town, or	Location o	of Death	- 011	4c.	County of De	ath		
			The Johns	Hopkins	HOSD 11	7.1		If Under	7410	le City		0.8	rthplace (State or Foreign		
	Funeral	1	5. Social Security Number 6. S	ex 7.Age 1XIM 2□F	(In yrs. last birth Y	rs. Months	Days	Hours	Min. 24	8. Date of Bir (Month, Da Sept 1	y Year)	007 M	country) aryland		
	Director	-	NONE Usual Residence of Decedent	2.			1	-	24	pehr r	J , Z	307 110	aryrana		
	land		10a. State 10b. County		10c. City, Town or Location						10d. Ins				
	Man,	ţo	MD		Ва	ltimore							1√ Yes 2 No		
	h the	Director	10e. Street and Number			10f. Z	p Code				10g. Citiz	zen of What C	Country?		
	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show critical Exercising the notified at		3926 Elmora Aven				21213					USA			
	r dea	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Dec	edent of Hi ecify Cuba	spanic Ori n, Mexicar	gin? (Spe i, Puerto				nerican Indian, iite, etc.		
98	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give 1☐ Yes 2 Year or Dates:			2X No	Specify:				Specify: b	lack		
ö	ural',	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E									nd of Busines	s/Industry		
75	- F 33	Completed	(Specify only highest gra	grade completed) (Give kind of work done durin life. DO NOT use retired)					t of worki	ng		,			
12	within	E	Elementary/Secondary (0-12) NONE	College (1-4or 5+		none					n	one			
D	it it it	0	17. Father's Name (First, Middle, Last,			TOTAL	unk	18. Mothe	er's Name	(First, Middle					
a	± 5 5 ₹	To B							Mon	ica Ke	cney				
Maryland 21215-0036	S E E		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Addres	s (Street a	and Numbe	er or Rura	I Route Numb	er, City o	Town, State	, Zip Code)		
Z	1 and 2 Health a tem 27 is		The Johns Hopkins	Hospital		00 N. W		Stree					37		
ore	Stall		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemetery	Disposition (No.), crematory or	ame of other plac	θ)	C	Date	20c. Lo	cation - City of	or Town, State		
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Baltimore,	permit. Page Department of Importent: If any injury of once.		21. Signauh a Funeral Sprice Lice	Wad, Dire	ctor	State Baltim	Anato	omy B	oard	655 W.	Bal	timore	Street		
			23a. Part. Enter the disease, or con-	plications that caused t	he death. Do n					or respiratory a	rrest,		Approximate Interval Between		
	Physician	Ş	shock or heart failure! List only Immediate Cause (Final		tory d	istres	2						Onset and Death		
	/Medical		disease or condition resulting in death)		consequence								1 11001		
н	Examiner		O with the title and distance	extren	ie pre	matu	rity						4 hours		
	n =	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	of):		1							
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Ö,	be executed sictan and burial-transit	Ä	resulting in death) Last	Due to (or as a	consequence of	or):									
8760,	icate be ex physician s the buria	dical		_ d											
9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	22a If you outcome a	of preamancy	_						33d Data of a	tolivon.		
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal death	3 Ectopic 5 Other (23d. Date of o Month	Day Year		
o.	t the de by the a tached t	ysic	1 ☐ Yes 2 DaNo 9 ☐ Unknown	4∐Pregnant at t 9☐ Unknown	illaed to enii.	3 CONTINUE	specify)								
۵.	that the od by detac		Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying	cause give	en in Part I	I.	23e. Did	tobacco u	ise contribute	to the cause of death?		
of Vital Records,	uires tha signed id be de	d by	maternal pret	erm del	ivery					10	Yes 2	X N₀ 3□	Probably 4 Unknown		
Ö	v requii been s should	ete								24a. Was	an	24b. Were	autopsy findings available		
Rec	The lav	Completed									ormed?	prior t death	o completion of cause of		
a	(9	ပိ	25. Was case referred to medical		 			26 Plac	e of Deat	1 ☐ Yes	200No	1 1	85 2/A 140		
Ξ	Physicien: r this certificatal director.	00	examiner?	Hospital:	nt 2 ER/Out	tpatient 3□ I	Oth Oth	er		me 5 Res		6 ☐Other (S	pecify)		
o	Phy eral d	n: To	27. Manner of Death	28a. Date of Injun (Month, Day		ime of	28c. Injun	y at		28d. Describe					
io	nding F ath. r: After e funer.	atio	1 Natural 5 Pending 2 Accident investigation		rear) II	ijury M		Yes 2□	No						
Division	r Atte	Certification:	3 Suicide 6 Could not to determined		ry - At home, fa	rm, street, fact	ory, office			28f. Location City or To			Rural Route Number,		
O	itel o Irs aft rel Di														
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 🔀 Certifying P (Check only one) 2 Medicel Exe	hysicien: To the best o miner: On the basis of and manner stat	examination and	n, death occurre d/or investigati	ed at the tir on, in my o	ne, date ai pinion, de	nd place, ath occur	and due to the red at the time	date and	and manner i place, and c	as stated. flue to the cause(s)		
	Fo th within Fo th	Me	29b. Signature and title of certifier			2	9c. Licens		_		29d. Da	te signed (Mo	onth, Day, Year)		
	- > - 0		DE Award Jo	umer m	D		RES	5-00	00		00	1120	12007		
			30. Name and address of person who	completed cause of de	eath (Item 23a) ((Type, Print)				0 11			1 1		
			Edward	Tanner	600	North	1 Wol	te St	ree	t, Balt	MOY	e, Mar	yland, 21287		
	St Regist	ate	31. Date filed (Month Pax Year) 20	32. Registra	r's Signature	house i									

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Kuntz 11:22 PM 2007 Marie 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL NA GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) St Thomas Virgin, Island 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months DOB: 11/04/1934 1 M 2 XF 72 Director 580-12-7173 Virgin, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 1 TYes 2 No Director NA Md. Baltimore 28a-f 10e. Street and Number 10g. Citizen of What Country? ō 21218 4305 Loch Raven Blvd. USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Black 'natural", Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Seamtress 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsa Creque George Osmond ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Daughter Joycelyn Nibbs 3700 Greensprings Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vigin St. Thomas, Western Cem. 10-4-07 Island 21. Signature Tuneral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisable or highly that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a the burial-1 Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Donknown END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe CONGESTIVE HEART 1 ☐ Yes 2 ☐ No ₽ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1☐Inpatient 2☐ER/Outpatient 3☐DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 ☐Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

31. Date filed (Month, Day, Year) 2007

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

PRACHI JOG

GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239 32. Figistrar's Signatur

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 21,2007 **Physician** Rufus Glenn Lockemy /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County 2133 Lodge Forest Drive Sparrows Point 8. Date of Birth (Month, Day, Year) Dec • 16, 1941 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Min. 1☐M 2□F Months Days Hours Dillon, S.C. 250-64-8712 65 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Baltimore County Maryland Sparrows Point Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tent of Heatth and Mental Hygiene.

nt: If item 27 Is marked other than "natural", or items 23a or ? 2133 Lodge Forest Drive 21219 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Agmed Forces? †El Yes 2□ No If Yes, Give Year or Dates: 1962-65 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify White 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n/a Elementary/Secondary (0-12) Clergy Church of God 7 Is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lacy Golman Lockemy, Sr. Virginia Burr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet Anne(nee Emge)Lockemy(Wife) 2133 Lodge Forest Drive Sparrows Point,MD. 21219 Date 26, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Sept. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Entombment Gardens Of Faith 2007 Rossville, Maryland Peaceful Alternatives Funeral&Cremation Ctr,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant sulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient Certification: To 1 🔲 Yes 2 ER/Outpatient 3 DOA 27. Manne Death 1 U atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation after death.

I Director: Ar
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dir 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Year)

DHMH 17 Rev 1/2001

e of death (Item 23a) (Type, Print)

29c. License number

1110

29d. Date signed (Month, Day, Year)

Donald Longest 07-06740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JINK UINK		1- For State Registrar	State of Ma	aryland / l	•	ment of He icate of De		entai Hyg		g. No. 200	7 3108	
Physici Medical Exam		1. Decedent's Name (First, N					-		Date of Death Month	Day Year	3. Time of Death 1530 hrs	
Medicai Exam	mei	DONALD EUGEN 4a. Facility Name (if not inst				4b. Cit	y, Town, or Locatio		August 30,	4c. County of Death		
		3000 Falls Road				Ba	timore	1900				
Funeral Director		5. Social Security Number	6. Sex		In yrs. last l		nder 1 Year If Ur			1, 1962 Co		
		Usual Residence of Decede 10a. State 10b. Cou		10	c. City, To	wn or Location	10d. Inside City Limits					
2	'n	MD			BAT	TIMORE					1 X Yes 2 No	
Maryland 28a-f show d at once.	ecto	10e. Street and Number					Zip Code	13-1	. 10	g. Citizen of What Cou	intry?	
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3, MD 21215-0036 and 2 shoutdoe filed within 72 hours after death with the Maryland fealth and Mental Hygiene term 27 is marked other than "matural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2		is Decedent Ev ned Forces?			edent of Hispanic C ecify Cuban, Mexic			14: Race - Amer White, etc.	rican Indian, Black,	
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15-0036 filed within 77 Hygiene. d other than , the Medical	omi	6TH 17. Father's Name (First, Mic	ridle Last)			LABORER	18 Moth	er's Name (Fi	irst Middle M	CONSTRUC	TION	
more, MD 21215-0036 Pages I and 2 should be filed within 72 tent of Health and Mental Hygiene, nnt: If item 27 is marked other than " in other traumatic event, the Medical	Be C	ROBERT LONGE						LMAH YC		arder Surrame,		
ID 2121 should be f and Mental 7 is marken	To	9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi									e, Zip Code)	
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Baltimore, ME permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traums		1 X Burial 2 Crem	ation 3 Remo	oval from State		natory or other pla		*		20c. Location - City or		
Itjm it. Pa itmen orfant y or o		4 Donation 5 Other 21. Signature of Funeral Ser			LO	RRAINE P		09/28	3/2007	BALTIMORE,	MD 21207	
Balt permit Depart Impor injury		Danell L.	11 -	i						IS, JR. FN TIMORE, MD		
Physician /Medical		23a. Part I. Enter the disease failure. List only one ca		that caused the	e death. Do						Approximate Interval Between Onset and	
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Ŋ	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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'60, ate be ex obysician ne burial -	Medical	X UNPENDED IF FEMALE:	#232	1,27,28a-	f, per	ME,g872, 1	0/24/07 TT			23d. Date of deliver		
OX 687(eath certifica : attending ph		23b. Was decedent pregnant past 12 months?	in the 1	Live birth		2 Fetal dea	th 3 Ecto	pic pregnancy	/		y Day Year	
OX (eath co	Physician/	1 Yes 2 No 9	Haknows	Pregnant at tim Unknown	e of death	5 Other (S	pecify)					
O. B at the d I by the tached		Part II. Other significant co			ut not resul	ting in the underly	ng cause given in	Part I.	23e. Did tot	 pacco use contribute to	the cause of death?	
res that signed libe deta	d by								1 Yes	2 No 3 Pro	bably 4 🗹 Unknown	
cords, F aw requires nas been sign 2 should be	Completed								24a. Was a autops		utopsy findings available completion of cause of	
Rec The la	Ĕ				-				perform 1 V Yes 2		es 2 No	
tal F	Be	25. Was case referred to me examiner?					26.Place of Deat	th (Check only	y one)			
of Vi Physi er this	유	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient Date of Injury		Outpatient 3	DOA Other	Nursing H		Residence 6 Othe	r: Scene	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	ion:	1 Natural) ((Month, Day, Year)			1 Yes 2		ink ink	ow injury occurred		
visic or Atte her des hirecto	fical		iivesiigalioii	$\frac{10}{100}$ $\frac{8}{30}$		Nd 3:20 pm , farm, street, fact	ory, office building,		f. Location (S		ural Route Number, City	
Div	Certification:	4 Homicide		ecify) fou	nd:sh	ore line		30	000 Fall	^{ate)} s_Rd. Baltimo	ore, MD	
Division of Vital Records, P.O. Box 68760, vittin 14 Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi										e(s) and manner as stat nd place, and due to the		
To t Com	Medical	29b. Signature and title of ce	and man	iner stated.			29c. License numbe		1	29d. Date signed (Mo		
		7011 11	117	1			O.C.M.E.			August 31, 2007		
٠,	-	30. Name and address of per	son who completer	d cause of deat	h (Item 23a	1)			<u>.</u>			
90		Zabiullah Ali, M.D.				111 Penn Str	eet, Baltimore,	, MD 2120	1			
St Regist	ate rar	31. Date filed (Month, Day, Ye SEP 2 7	2007	∠Registrar's	Signature	Agricul						
								_		OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien2007

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2007 **Physician** 23, 12:42 P M Sept. Kathryn E. Langenfelder /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Edenwald Towson 8. Date of Birth (Month, Cay, Year) 23 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 6 Sax **Funeral** Min. Months Days Hours 1 M 21/2 XF 83 220-36-6910 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other traumatic avant, If a Marical Examinar many injury or other many or other many injury or other many or 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 1 Tes 2/10/0 Director Towson Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21286 800 Southerly Rpad Unit 1106 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albright Elizabeth William Williams ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 800 Southerly Rd. Unit 1106, Towson, MD. Dr. Henry Langenfelder (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 Cremation 3 Removal from State 09/26/07 Baltimore, MD. Druid Ridge Cemetery 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3425 disease or condition resulting in death) aCISRIT MAU UNSCULAN ACCIDINAL /Medical Due to (or as a consequence of) Examiner compic voscu Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of 171340311 Examiner physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Withhown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 213/110 To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 virsing Home P 5 ☐ Residence 6 ☐ Other (Specify) this Diractor: After thi 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c, Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of perifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 SIS CAMP MEADIR RO. CINITHOUN 32. agistrar's Signature SITANIE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** pept. nwood /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, Examiner Birthplace (State or Foreign
 Fountry) Date of Birth (Month, Day, Year) 8. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. 1 M 2 □ F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Funeral Director Maryland 7 more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Sister 19b. Mailing Address (Street and Number or Rural Rou e Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2808 Riggs SO 1-Williams 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Joseph L. Kus 21. Signature of Puneral Service Licens WiNorth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terminal Acquived /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: led by the attendin detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9□Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□No 2 No 1☐ Yes 1 ☐Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA P After this 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kioung, 031865 mion-Dor

State Registrar

DHMH 17 Rev 1/2001

Rm 206

821

Baltimorp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

mian-Door

31. Date filed (Month, Day, Year)

State Registrar 6001 Muncaster Mill Road, Rockville, Maryland

M.D.

32. Pegistrar's Signature

Genevieve Wroblewski,

31. Date filed (Month, Day, Year)

Physician

Examine

Funeral Director

	For State Registrar	State of M	larylan	-	irtment of I <i>tificate of</i>	Health and Death	Mental Hy	_	2007	3109		
nn al	1. Decedent's Name (First, Middle, Michele A.	McGowan					2. Date of D Month Septen		7 2007	3. Time of Death		
er	4a. Facility Name (If not institution, Gilchrist Cente 5. Social Security Number 375–60–9230	r for Hospi	ce Ca	re last birthday) 55 Yrs.	Towsor If Under 1 Year Months Days	If Under 24 Hrs	8. Date of B	irth	C			
	Usual Residence of Decedent 10a. State 10b. County		,	, Town or Lo	cation		0011 27	1,52	111110	10d. Inside City Lim		
ctor	MD Harf	ord	Fo	rest H	i11			1 □ Yes 2 🗶				
Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What C	ountry?		
Funeral	1416 Persimmo	n Place 12. Was Deceden	t Ever in III	S 12 1	21050		US.			A - American Indian,		
۾	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 X Divorced	? No :	'	f Yes, specify Cul I∐Yes 2 X No	Hispanic Origin? (s ban, Mexican, Puel Specify:	rto Rican, etc.)		Black, Whi				
Completed	15. Decedent' (Specify only highes: Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give life. L	DO NOT use retire	e during most of wo	orking	16b. Kind	of Business	/Industry		
S	17 Fathara Nama (First Middle I	2		Retai	1 Sales	19 Mother's Na	me (First, Middle		tail			
Be C	17. Father's Name (First, Middle, L Archie McGow					1			urname)			
2	Archie McGowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State											
1	Judy Terrill -			1416	Persimmo	n Place,	Forest	Hi11.	MD 2	21050		
	20a. Method of Disposition 1 Burial 2XICremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 20c. Location - City or Town, State 9/27/2007 Baltimore, MD											
	21. Signature of Funeral Services				Name and Addr		ty of Ma	arylan	d. Ind			
edical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):											
Physician/Medi	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								d. Date of de Month			
þ	Part II. Other significant conditio	* '		í		iven in Part I.		e. Did tobacco use contribute to the cau		o the cause of death		
Completed	-						aut	24a. Was an autopsy autopsy performed? 1 Yes 2 WNo 1 Yes 2 No				
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tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, E	jury	28b. Time of Injury	28c. Inju		Home 5 Res			ecity MOSPICE		
Certification	3 Suicide 6 Could n 4 Homicide determi	20e. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office	9	28f. Location City or To	(Street and own, State)	Number or F	lural Route Number,		
Medical C		Physician: To the best xaminer: On the basis and manner:	-6	Alon andles in	continuation to make	and all and all and a second	and the second section of the second		باد اد د د د د د د د د	- A- Ab		
M	29b. Signature and title of certifier	w		3_	29c. Licen	58303		29d. Date	signed (Mon	th, Day, Year)		
	30. Name and address of person of the same	tho completed cause of	death (Item	23a) (Type, Oi N C	Print)	St Ponsu	~ ME	212	TY.			
te ar	31. Date filed (Month, Day, Year)	N.	strar's Signa	ture	We)		_					

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, 2007 Jessalyn Garvey Meier September 9:45am ^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Charlestown Retirement Center Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Dec. 27, Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Months Days Hours 142-07-7473 88 Dec. 1918 New Jersey Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 709 Maiden Choice Lane RGS 228 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Home Maker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas J. Garvey Marguerite Leeson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Pepperdine Circle Catonsville , MD 21228 Nancy Meier/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date West Arundel Crematory 9-27-2007 ☐ Burial 2 Cremation 3 ☐ Removal from State Odenton, Maryland 4 Departion 5 ☐ Other (Specify) ol Funeral Service L APRILITATION OF THE PROPERTY OF A PRINCE OF THE PROPERTY OF TH Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f shov idical Examiner must be notified at

r than the Me

of Health and Mental Hygie f item 27 is marked other t r other traumatic event, th

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

Director

Funeral

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Completed

Be

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death or nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tran attending p been signed by the should be detached certificate has breactor, page 2 s funeral

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

After

within 24 hours a To the Funeral L

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical ò Completed Certification: To Be nours after death.

neral Director: A
rilled in by the fu

25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 Natural

IF FEMALE:

2 ☐ Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

24b. Were autopsy findings available prior to completion of cause of autopsy performe 2 No 2□No 26. Place Death Check onl one

Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Yes 2 🗆 No

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100RETT

5 Pending investigation

6 ☐ Could not be determined

State Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and the of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SEPT 14, 11:50 AM WILLIE MAE MOSES 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2016 RAYNER AVE. BALTIMORE If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🔀 F Director GA 212-42-3155 64 JAN. 11, 1943 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 XYes 2 □ No Examiner must be notified Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 21216 death v Funeral 2016 RAYNER AVE USA Race - American Indian, Black, White, etc. 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 2K No 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12TH CHEF HOTEL permit. Pages 1 and 2 survey. Department of Health and Mental Hygie Important: If item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 JAMES TARVER ANNIE MYRTLE CONEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 RAYNER AVE., BALTIMORE, MD 21216 REGINA DAVIS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5500 O DONNELL ST. Important: If it any injury or o once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 21224 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW 09/22/2007 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner **To the Hospital or Attending Physician**: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months 5 ☐ Other (specify) TYPE 2 STATE 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 2 1 No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 页 📈 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Desidence 6 ☐Other (Specify) 27. Manner Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Jural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Il Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Vithin 24 hours are. To the Funeral Dir 29a. Certifier i 🗓 😋 📆 Ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

mpleted cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9 20ď7 25 РМ Jean F. Murphy 2:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Ctr 9. Birthplace (State or Foreign Country) PA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 6/18/1926 Hours 1 □ M 2 🗙 F 165-22-1138 81 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Anne Arundel Glen Burnie MT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Virginia Ave 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Ş Q Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Pleyo Sarah 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1418 Pond Ridge Dr Pasadena MD 21122 Mr. Norman Murphy/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 □Removal from State 9/29/2007 Glen Burnie MD 4 ☐ Bonation 5 ☐ Other (Specify) Glen Haven Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation M01364 2nd Ave SW Glen Burnie MD 21061 Srvc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be e. . Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mo Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1∐ Yes 2 🗌 No 2 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient DOA this 27. Manna f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral C Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

2

ature and title of certifier

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Pric

Registrar

29d, Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** SEPTEMBER LEVA 23 07 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GOOD SAMARITAN HOSPITAL ALTIMORE ALTIMORE If Under 1 Year | If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours November 16° 80 1 ☐ M 2 💢 F 1926 Pennsylvania 220-20-4493 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at N/A XX Yes 2 □ No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 5009 Frankford Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian "natural", or items 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner, once. Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2/X/No Specify. Specify: White Completed by 3 K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Chester Corle Camilla Replogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mary K. Haller/Daughter 25 Boy Scout Road New Oxford Pennsylvania 17350 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9/29/07 Towson Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc mistina 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4R7NGEAL /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HMONIC ()BSTRUCTIV Due to (or as a consequence of): IRRHASSI Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknowh been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 ♥Únknown TNFECTION 1 ☐ Yes 2 No 3 Probably Completed 24a, Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

SEP 2 7 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner-stated.

SAMARITAN HOSPITAL BALTIMORS

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2007									
	Physici /Medic		Decedent's Name (First, Middle, Last)	Adeline		Merkle		2. Date of Death Month Sept.	Day Yea 21. 200	M		
	Examir	_	4a. Facility Name (If not institution, give stra 515 Southern Aven				undalk	БСРС.	4c. County of De	timore Co.		
i.	Funeral Director		5. Social Security Number 214-26-9910 Usual Residence of Decedent	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 1	Year) (irthplace (State or Foreign Country) Pennsylvania		
	Maryland a-f show ified at	ctor	10a. State 10b. County	altimore	own or Loc	pation	Dundalk			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	h with the 23a or 28 st be noi	al Director	10e. Street and Number 515 Southern Ave	nue		10f. Zip Code	21224	10	g. Citizen of What of United	Country? States		
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to the that hand Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2★ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 1 No		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. White		
21	filed within 72 ho Hygiene. ther than "natur ent, the Medical."	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12 Years	15. Decedent's Education (Specify only highest grade completed) mentary/Secondary (0-12) 12 Years College (1-4or 5+) 12 Years Cook ther's Name (First, Middle, Last) Grover Kilmer Grover Kilmer Mormant's Name/Relationship (Type. Print) Donna Button (Daughter) Burial 2XICremation 3 Removal from State Donation 5 Other (Specify) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook 18. Mother's Name (First, Middle, Normal Relationship (Type. Print)) 19b. Mailing Address (Street and Number or Rural Route Number, 1912 Kelmore Road Dundalk, 1912 Relationship (Type. Print) Cook 18. Mother's Name (First, Middle, Normal Relationship (Type. Print)) 19b. Mailing Address (Street and Number or Rural Route Number, 1912 Kelmore Road Dundalk, 1912 Relationship (Type. Print) 19b. Place of Disposition (Name of cemetery, crematory or other place) 19b. Place of Disposition (Name of cemetery, crematory or other place) 19b. Place of Disposition (Name of cemetery, crematory or other place) 19c. Place of Disposition (Name of cemetery, crematory or other place) 19c. Place of Disposition (Name of cemetery, crematory or other place) 19c. Place of Disposition (Name of cemetery, crematory or other place) 19c. Place of Disposition (Name of cemetery, crematory or other place)	6b. Kind of Busines Baltimore Public Sc	County						
Maryland	2 should be filed w and Mental Hygie Is marked other t raumatic event, th	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Grover	Kilmer			18. Mother's Name	(First, Middle, M Florence	,			
-	ind 2 sho alth and I 27 Is ma er trauma			·		•		,				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra		20a. Method of Disposition	20b. Place ceme	etery, cren	natory or other place) :	-	Oc. Location - City of			
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	Ca.		Duda-Ruck 7922 Wise	Funeral Ave. Du	ındalk, N	Maryland	and 21222 Approximate		
	Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	1		7			Approximate Interval Between Onset and Death 2-79		
Ļ	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence CHROSEL C Due to (or as a consequence	ce of):	Chros			lls Tu	575		
8760, 4	icate be executed physician and s the burial-transit	dical	that initiated events c resulting in death) Last	Due to (or as a consequence			· igreij			loys		
P.O. Box 6	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknowh	If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year		
rds, P	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contri	buting to death but not resulting	g in the ur	nderlying cause give	n in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown		
		Completed						24a. Was an autopsy perform	prior t			
r Vita	Physiclan: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes 2 \(\text{No} \)	spital: 1	Outpatien	t 3 DOA Othe	26. Place of Deatl		nce 6 Other (S	pecify)		
	ffel	Certification: 1	27. Manner of Death 1 Natural 5 □ Pending investigation 3 □ Suicide 6 □ Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of injury - At home, building, etc. (Specify)	b. Time of Injury , farm, stre		'es 2□No		eet and Number or	Rural Route Number,		
Ō	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physic	ian: To the best of my knowled					use(s) and manner			
	To the Hc within 24 To the Fu completel	Medical	(Check only 2 Medical Examine one) 29b. Signature and title of certifier	r: On the basis of examination and manner stated.	and/or in	29c. License			ite and place, and c			
	⊢ ≯ ⊢ ŏ			and the same of th		DI	422 1		9.21	. 07		
	le		30. Name and address of person who com T. A. A. Re 2v /	2 2 7	0 6	1 16	67 M	2/2	21			
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 7 200	32. Egletrar's Signature 7	4	well)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day SEPT. 24,2007 7:10a MITCHELL, SR. THOMAS LEE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST TAKOMA PARK MONTGOMERY CO. HOSPITAL Date of Birth (Month, Day, Year) 2-29-1936 9. Birthplace (State or Foreign Country) S . C . 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 1 4 M 2 ☐ F Months 251-48-9011 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No VA ALEXANDRIA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22304 U.S.A. 61 GARDEN DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: BLACK Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SALESMAN 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSANNA MITCHELL 19a. Informant's Name/Relationship (Type. Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA Y. MITCHELL -GARDEN DRIVE, ALEXANDRIA, VA 22304 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 9-29-07 RIVERDALE, MARYLAND 22. Name and Address of Facility RONALD TAYLOR, II FUNERAL HM 21. Signature of Funeral Service Licensee 108 WEST NORTH AVENUE, BALTIMORE, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last GEREMAL DISEASE IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the leath contificate be exec

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

items 23a or Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice.

Director

Funeral

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Completed

Be

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Examine and burial-trar by Physician/Medical Completed Be Certification: To 24 hours after death Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

	9 ☐ Unknown	9 DONKHOWII	
aı (art II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. HEART FAILURE	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
_			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
:5	. Was case referred to medical	26. Place of Death	(Check only one)
	examiner? 1 ☐ Yes 2 万 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 ☐ Residence 6 ☐ Other (Specify)
7	7. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

completely

within 2

29a. Certifier

and manner stated

29d. Date signed (Month, Day, Year)

MD

AMOVER PARKWAY GREGGEBELT MARYLAND 20770

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

Baltimore, Maryland 21215-0036

Sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Appendix of Health and Mental Hygiene.

Marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one proce.

Examiner

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division or Vital Records, P.O. Box 68760,

If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□M 2√F 216-40-8618 Feb 12, 1944 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Fairground Road 20678 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify þ Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) licensed cosmotologist cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Finley Paul Maeder Thelma Victoria Dolphin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Nowatski/daughter 220 Fairground Road Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Septice Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director ins Baltimore, MD 21201 23 Part Enter the disease, or some cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cordio respiratory Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): dis 6016. COLOCCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine hypertension Due (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred **⁴**-☐Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060638 9/19/07 MD N. Mendon 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL IN 110. 8 + 906 PRINCE Registrar's Signature 31. Date filed (Month, Day, Year) State

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Registrar

SFP27

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary and PSE partitle 887 Health and Mental Profess 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** HERSON 2007 NN RA /Medical (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner 1timo RE owson Rtor f Under 1 Year | If Under 24 Hrs. 7. Age (Inters. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year) Months Days Hours Min. 1 M 2 1 F 216-50-3036 Usual Residence of Decedent AROLINA Director nov. death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director SIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2104 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Ack <u>م</u> 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Be Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last ENNE ပ (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Department of Health ar Important: If item 27 is any Injury or other trauonce. 20a. Method of Disposition 10643 O/UmbiA 20b. Place of Disposition (Name of cemetery, crematory, or other place Date 20c Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Remova! from State 5 ☐ Other (Specify) 4 □ Denation Af Funeral Service Łૌ¢ensee Q 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final navels **Physician** a horn A disease or condition resulting in death) m /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 2 2 No To the Hospital or Attending Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ltorpice ၉ 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 242007 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh G Buc MIC 6701 31. Date filed (Month, Day, gistrar's Signature 32. Year) State Registrar 2007

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The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, ō

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State Registrar Nakul Goyal, M/D. 31. Date filed (Month, Day, Year)

30. Name and address of berson

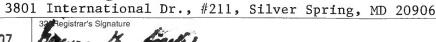
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2007

29a. Certifier

(Check only

29b. Signature and



No completed cause of death (Irem 25a) (Type, Print)



1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D38457

29c. License number

29d. Date signed (Month, Day, Year)

September 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 05 Beulah Elizabeth Roeder 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore St. Agnes Hospita N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 18, 1906 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕅 F 220-56-2231 100 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show la or 28a-f sh t be notified 1 ☐ Yes 2 No Maryland Baltimore Director Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Newburg Avenue 21228 23a **USA** Examiner must Funeral Items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or Iter 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Kuntz Irene Schisler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Carl Roeder, Son Health 16009 Kerr Road Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1:
Department of He
Important: If iten
any Injury or oth 1 X Burial 2 □ Cremation 3 □ Removal from State 10/02/07 Gwynn Oak, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Lieby MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and bunial-trar physician s the buna Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year 4□Pregnant at time of death 9□Unknown Month Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and t

Registrar

State

31. Date filed (Month, Day,

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death (Item 23a) (Type, Print)

person who completed cause of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia	an	1. Decedent's Name (First, Middle, Last	")							2. Date of Dea Month	ath Day	Year	3. Time of Death
/Medic		Jeffrey Sc								9	21	2007	10:41A.M
Examin	er	4a. Facility Name (If not institution, give						r Location of D le Grace		4c. County of Death Harford county			
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Director		219-52-5056 ×	X M 2□F		57 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 12/18/	1949	Dunda	place (State or Foreign lotry) 1K, Marylan
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E SECTION AND A	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13. \	Was Dece f Yes, spe	dent of H	lispanic Origin an, Mexican, P	? (Spec Juerto P	cify Yes or No- Rican, etc.)	- 1	4. Race - Amer Black, White	
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other traumatic avent, the Medical	ဥ	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Addres	s (Street	and Number o	r Rurai	Route Numbe	er, City or	Town, State, Zi	ip Code)
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		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stat		Place of Dispo	natory or	other plac	ce) Ser		ate nhor	20c. Lo	cation - City or T	own, State
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eny injury or of once.		21. Signature of Funeral Service Licens	5/1		22 De	Name a	nd Addre	ss of Facility 2	2325	York	Rd.	Timoniu	m, MD 21093 ion Ctr., F
	_	23a. Part1. Enter the disease, or comp	lications that cause	ed the dea								acrenat.	Approximate Approximate
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for use as	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	aldeath 3□	Ectopic p		,			2	3d. Date of deliving	very Day Year
tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of o	death 5□	Other (s	pecify)					141011111	Day Tou.
	y Ph	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the u	nderlying	cause giv	ren in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
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	7	1 ✓ Yes 2 ☐ No 27. Manner of Death	Hospital:		ER/Outpatier			4 🗀 Nursi				Other (Spec	ufy)
eun eun	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	28b. Time of Injury	м	28c. Injur Wor	yaτ k? Yes 2 ∐No		8d. Describe h	now injury	occurred	
	ifica	3 Suicide 6 Could not be determined	28e. Place of I	njury - At h	ome, farm, str					8f. Location (S	Street and	d Number or Ru	ral Route Number,
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DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09/23/2007 **Physician** Flossie Belle Rohrbaugh 12:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/09/1920 Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗶 F Hours Min Director 233-34-5607 87 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Directo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 960 10th Street 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspect. General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Gabriel Turner Emma Goldizen ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Glenda Shatley/Daughter 960 10th Street, Pasadena, MD 21122 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Mem Pk 09/26/07 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sentic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has e 2 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: ပ 1 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 T DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 attending physician the certificate To the Hospital or Attending Physician: this after death

Director: within 24 hours aff

To the Funeral D

completely filled in

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Year)

5 31. Date filed (Month, Day,

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

License number

2056

29d. Date/signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day ESTHER ROUSSET 21, SEPT 2007 10:05 PM 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 172 OTHELLO CT. WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 1 🗙 F 9/7/1934 075-28-8713 73 PUERTO RICO Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 172 OTHELLO CT. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1XYes 2□ No Specify: PUERTO RICAN Specify: WHITE 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER ACCOUNTING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOPEZ JUAN DARIA GONZALES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSALIND ESTEVES -DAUGHTER 172 OTHELLO CT., WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State MEADOW BRANCH CEM. 9/25/2007 WESTMINSTER, MD □Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or irjuny that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2□ № 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

2 No

1 ☐ Yes

27. Manner of Dath

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

1 Natural

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

o e

items 23a c

ı "natural", or items ledical Examiner п

the Medical

. Pages 1 and 2 should be fill trent of Health and Mental Heart: If item 27 is marked oth jury or other traumatic even

permit. Page Department o Important: If any Injury or

Director

Funeral

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Be Completed

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

burial-tran the attending p detached page 2 s certificate this

that the death certificate be executed

Hospital or Attending after death Director: filled in by the

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral L

State

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

Blvd.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Hospital:

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated

2059 Balt

SEP 2 31. Date filed (Month,

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				riease	State of Marylan				-	•	Die.		
				1 - For State Registrar	State of Marylan		rtificate of L			Reg. N2 0 (37	31107	
	100	Physici	an	1. Decedent's Name (First, Middle, Li	ast)				2. Date of De Month		Year	3. Time of Death	_
9		/Medic	al	Raymond Rich			45 O'S T-	Landing of David	9	4c. County	2007	16:45 M	
		Examin	er	4a. Facility Name (If not institution, gi	ave Heroital	Caroba	ROSec	Location of Death		Bal.	3	n.10	
		Funeral	* (9 C MC)	5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry)	
		Director		219-40-1883	1XDM 2□F 63	Yrs.	World Days	Tiodis Willi.	March		M	aryland	_
Ž		ehow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits	_
		the Man 28a-f eh	ctor	Maryland Balt	imore		Balti	more				1 ☐ Yes 2X No	
\langle		vith the	Director	10e. Street and Number			10f. Zip Code	226		10g. Citizen of 1			
2		72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow Lical Examiner must be notilied at	Funerai	9117 Santa Rita I	12. Was Decedent Ever in U	.S. 13.		L 236 spanic Origin? (Sp	ecify Yes or No		. S.	A • can Indian,	_
0	9	after o		1 ☐ Never Married 2 【X Married	Armed Forces? 1 X Yes 2 □ No 196 If Yes, Give	52-	Was Decedent of Hi ff Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puerto	Rican, etc.)		ck, White,	etc.	
\sum	5-0036	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 196	8		1		Specify	v	Vhite	
RAYMON	_	in 72 n "nat	Completed	15. Decedent's E (Specify only highest gi	rade completed)	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	furing most of work	king	16b. Kind of B	usiness/In	ndustry	
3	212	d withir giene. er then	Com	Elementary/Secondary (0-12)	College (1-4or 5+) 2	S	r. Systems	s Analyst		Compu	ter (Company	
	pu	be filed ital Hygie d other event.	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam					
2	Maryland	2 should be fited and Mental Hygi Is marked other eumatic event.	ပ္	John James Robi 19a. Informant's Name/Relationship		19h Maili	ing Address (Street a			Weslosk		n Code)	_
OBIN,	Z			Susan E. Robin (Santa Ri						
0	Baltimore,	ges 1 and 2 tof Health If Item 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	20b. F		osition (Name of ematory or other place		Date	20c. Location			
X	ij	Pages tment of I tant: If It		4 ☐ Donation 5 ☐ Other (Spec	Be1		Memorial G						
	Bal	permit, Pages Department of H Important: If Its eny injury or ot		21. Signature of Funeral Service Lice	l 1 0 0 0 x		2. Name and Addres						
	. *			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deat							Approximate Interval Between	
		Physician		Immediate Cause (Final disease or condition	Stroke							Onset and Death	
	6	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	P						
ı			er	Sequentially list conditions,	b. Encloca Due to for as a sone so	relit	15						
		outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
V	60,	be executed sictan and burial-transit	Ex	resulting in death) Last	Due to (or as a conseq	uence of):							
		a = a	dicai		d .								-
	Box 68	leath certificate b attending physic I for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Da	te of deliv	rery	
	Ö.	ne death the atte	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Mo	onth	Day Year	
	P.O.	that the died by the detached		9 Unknown Part II. Other significant conditions		utting in the	undarkina nousa aw	o in Part I	23a Did t	ohacco usa con	tribute to	the cause of death?	-
	ds,	uires ti signe Id be c	d by	Fattil. Other significant conditions	contributing to death but not res	anding in the t	undenying cause give	en in Fait I.		Yes 2 12 No		bably 4 Unknown	
	000	s been standed	Completed						24a. Was		Were aut	opsy findings available	_
	Re	The lav ate has page 2	mo.				V		auto perfe	ormed?	prior to co death? 1 \(\sum \text{Yes} \)	ompletion of cause of 2 No	
	/ita	cian: entific ector.	Be	25. Was case referred to medical examiner?	Manial		Lou	26. Pface of Dea	th (Check only	оле)			-
	of	Physician: The la ir this certificate haves aral director, page 2	2	1 Yes 2 No	A-1	ER/Outpatie		4 Nursing H		dence 6 Oth		fy)	
	ion	nding F ath. r: After e funera	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Year)	Injury	Worl	(? Yes 2 □ No		,,			
	Division of Vital Records,	or Attended Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of fnjury - At h building, etc. (Specif	ome, farm, st	treet, lactory, office		28f. Location (City or To	Street and Numb wn, State)	oer or Run	al Route Number,	
	J	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	dical Ce	29a. Certifier the Certifying P	hysician: To the best of my kno miner: On the basis of examina	owledge, dear	th occurred at the tim	ne, date and place,	and due to the	cause(s) and made	anner as s	stated.	
		the F thin 24 of the F m lete	Medi	one) 29b. Signature and title of ceptifier	and manner stated.		29c. License		and,	29d. Date signe			_
. 40		or To con) (ABO.			DLY	408		9/2	4/15	7	
	1			30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре	, Print)			194-1	-1/	21237	_
		LQ		Bahrani f	Ishlan D	- 90	DO From	Khin S	quore	Dow	e P	Salta MA	
	T)	Sta Registr		SEP 2 7 200	2. Registrar's Signa	Spel	1						

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

the

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007

31109

		4	For State Registrar	State of Waryta		tificate of D	Death	Reg.	No.	01107			
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death			
	Physicia /Medic		Margaret M.	Schmidt				September	26, 2007				
	Examin		4a. Facility Name (If not institution, give sti	eet and number)		4b. City, Town, or	Location of Death		4c. County of Deatl				
			Holly Hill Ma			Tov	VSON If Under 24 Hrs.	8. Date of Birth	Balti				
	Funeral Director		216-12-2392	7. Age (In yr.	s. last birthday) Yrs.	Months Days	Hours Min.	March 3,	1911 Ma	nplace (State or Foreign untry) aryland			
2	* *	-	Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or Lo	cation				10d. Inside City Limits			
fract	f eho	5	Maryland N/A			Ralt	imore			1X Yes 2 No			
4	28a-	rect	Maryland N/A 10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?			
4	3a or	Ö	1633 Stonewood Roa	d		21:	239		U. S. A	Α.			
bush of the Hood	ms 2	Funeral Director		2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White				
Z13-0030	permit. Pages 1 and 2 should be filed within 7.2 frouts after bearth with the way year. Department of Health and Mental Hydiene. Important: If them 27 is merked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No			Specify: Wh	ite			
	natur lical	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done d	uring most of work		b. Kind of Business/	Industry			
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7	lygier her th		17. Father's Name (First, Middle, Last)			Salespers		e (First, Middle, Ma		Store			
yland	ntal H ed ott	Be						inia V. H					
	d Me mark matic	2	Charles C. Rivers 19a. Informant's Name/Relationship (Type	e. Print)	19b. Maili	ng Address (Street a			City or Town, State, 2	Zip Code)			
Mar	than than 27 is i		Neil C. Schmidt (S			-			, Maryland				
<u>σ</u> .	Heal Heal tem 3		20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other place			c. Location - City or				
	ages ent of nt: #f i y or		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		Crematory	· .	s/ 2007 Ba	altimore,	Maryland			
Baitimore,	Departmont popular modernar mo		21. Slanature of Funeral Service License		2	2. Name and Addres	s of Facility Scl		uneral Ho m, Maryla				
45			23a. Part1. Enter the disease, or complic	ations that caused the de	1					Approximate Interval Between			
)§		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Athero school or cardio-Varcellar disease)											
	Physician /Medical			Due to (or as a cons		a cara	i D- Vacio	wall c	COCCO C				
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68760	tificate be executed og physician and as the burial-transit	edical	L d										
O. Box 6	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes	Sc. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of			23d. Date of de Month	livery Day Year					
<u>Ч</u>	hat th od by setacl	Phy	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?			
S S	rires tha signed t be del	l by	H. aderrian	Drenousi	a	,		1 ☐ Yes	2 No 3 P	robably 4 Unknown			
Records,	e law requir has been si je 2 should 1	Completed						24a. Was an autopsy perform	prior to				
		e Co	25. Was case referred to medical				26 Place of Dea	th (Check onl. one		s 2□No			
Vital	Physician: r this certific ral director,	o B	eyaminer?	ospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth			nce 6 Other (Sp	ecify)			
on of	ting Afte fune	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year		of 28c. Injur	yat k? Yes 2 □ No	28d. Describe how	v injury occurred				
	deat deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, s ecify)	treet, factory, office			ocation (Street and Number or Rural Route Number, Sity or Town, State)				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Physical Certified Physical Certifie	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	, and due to the car irred at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)			
	o the of the ortho	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		d. Date signed (Mor				
)	F F F 8		I Keuleer	near M	0.	DE	454	9	sentembi	r 27,200			
1	V		30. Name and address of person who co	impleted cause of death	(item 23a) (Type	e, Print)	- '		4)				
Q	1		1205 York Rd	mpleted cause of death Surf 35 32 Registrar's S	3, lie	therville	e, Mi	0 2109	3				
	St	tate	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	and a	-						
	Regist	trar	SEP 2 7 20	Il preme	10 14	A STATE OF THE PARTY OF THE PAR							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25, Year **Physician** Elizabeth Jean Hmber 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Ctr 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 218-50-5812 1 □ M 2 ▼□ F 58 Director MD 12/28/1948 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov iral", or Items 23a or 28a-f shov Examiner must be notified at Anne Arundel MD 1 ☐ Yes 2 No Director Hanover 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7420 Phelps Rd. 21076 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Buyer Produce permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lipiny or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donaldson Thomas Betty Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Swann/Husband 7420 Phelps Rd Hanover MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial | 10/1/2007 Elkridge 4 ☐ Donation _ 5 ☐ Other (Specify) Sarvice Licurisee 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral M01364 2nd Ave SW Glen Burnie MD 21061 Srvc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown/ ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 No death? 1 ☐ Yes certificate 1□ 2 No Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Tes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this . Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation **◆** Natural Injury within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, 32. Recutrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Shackleford 15 Johnny /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death, Examiner Baltimore SQUARE In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. **Funeral** Days 1 M Months Hours Director NA Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show uniner must be notified at 1 Yes 2 No Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 21212 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be ShackLeford URYIS ncess permit. Pages 1 and 2 should Department of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6121 mother PRIVE Parkway Princess 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State gardeny Faith 4 □ Donation 5 □ Other (Specify) 21. Sign were of Jungal 1639 10 Roadwa e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-List only one cause on each line. Approximate Interval Between Onset and Death piratory arrest 23a. Part1. Enter the d shock or heart fa Immediate Cause (Final disease or condition resulting in death) ever spea and **Physiclan** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a cons Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe res 2 has page 2 1∐ Yes this certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 ☐ Yes မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Datersigned (Month, Day, Year) 29c. License numbe 29b. Signature and title erson who completed Registrar's State

Registrar

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amend, item, 20b per / fb, 9871, 9-27-07, vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Doriszel Sept 23, 2007 6:20an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3400 Mayfield Ave.

5. Social Security Number 6. Sex Baltimore Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Director 47 220-78-4269 May22,1960 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Director 1 □X es 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. by Funeral 3400 Mayfield 21213 Ave. U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GED HairDresser Self Employeed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ <u>Viola Shears</u> <u> Ronnie_Johnson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Viola Goods/mother</u> 3400 Mayfield Ave. Balto. MD 21213 20b. Place of Disposition (Name of panetery demator crothe place) 20c. Location - City or Town, State 20a. Method of Disposition Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from Balto, Md. 4 □ Donation 5 □ Other (Specify) 21. Inature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician breast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 🔲 Yes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) DYOSSY 912412007 MP completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Bultimer 21202 31. Date filed (Month, Day, Year) SEP 2 strar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

3altimore, Maryland 21215-0036

r 28a-f show notified at ò must be item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu al Hygiene. n and Mental F Item 27 I permit. Pages Department of Important: If it any Injury or o **Physician** /Medical Examiner physician and sthe burial-trans led by the attending particle detached for use as Certification: To After t after death the filled in by To the Hospital within 24 hours at To the Funeral E 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 9-24-2007 00053333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21209 Baltimore Avenue 31. Date filed (Month, Pay, Year) 32 Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 19, 2007 **Physician** Dorothy Virginia Troch 7:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 1204 Locust Avenue Arbutus 8. Date of Birth (Month, Day, Year) 9. Distriction of Country July 20, 1935 Mary Land 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 💢 F 77 219-30-7695 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 1204 Locust Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hammilton Brown Dorothy V. James ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Strauss/Daughter 5304 E. Glen Road Ellicott City MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other of 20a. Method of Disposition Date 20c. Location - City or Town, State Loudon Park Cemetery 1∭X Burial 2 □ Cremation 3 □ Removal from State 9-25-2007 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Sign ture of Funeral Service Lice : ee Ambrose runeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the meath shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death HU Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or ell a lonsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter unverlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DO 061825

Pd cause of death (Item 23a) (Type, Print)

MD 3028

Brown wath Aw Bulf, MP 21218

32. Bristrar's Signature 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year) SEP 27



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3		30 Name and address of perso Laron Locke MD.		•	se of death (I al Examine		nn S	Street, E	altim	ore, MD	2120)1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland began the Series of Health and Mewal Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ernest Earl Trimble 1528 Sentember 24 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAMARITAN Imore Birthplace (State or Foreign Country)
 PA 6. Sex If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **№** M 2 F 218-32-6510 70 Aug. 8, 1937 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 10b. County 1 ∐Yes 2 ⊠No MD Baltimore Director Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21221 6 Mingo LAne USA Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Plumbing Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Sarah Snyder Elwood E. Trimble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 is any Injury or other trau Bradley T. Trimble /son 1320 Wabash Drive BelAir MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 9/26/07 Baltimore MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. cate has been signed by the a page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 25. Was case referred to medical funeral director, 26 Place of Death (Check only one) Be 2 DER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 2 ☐ Accident 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00018230

State Registrar KALATHIC

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHASHIDHARAN

32. Registrar's Signature

5601 Loch Raven Boulevard,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes a com-

			for State Registrar		ertificate of Death		2007	31117
	Physici /Medi		1. Decedent's Name (First, Middle, La	Doris Arlene Turn		2. Date of Death Month Septer	mber 21, 2007	3. Time of Death 5:45 р. м
	Examir		4a. Facility Name (If not institution, gi	<i>r</i> e street and number) 1650 Sandlight Court	4b. City, Town, or Location of Death	umbia	4c. County of Death	ward
	Funeral Director		579-60-4212	Sex 7. Age (In yrs. last birthda 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, May 7,	Yeard Cou	place (State or Foreign intry)
	Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State Maryland 10b. County	Howard 10c. City, Town or	Location Columbia			10d. Inside City Limits 1 ∐Yes 2 11 No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 9650 Sandlight Coul	t	10f. Zip Code 21046	10	og. Citizen of What Cou	nto?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Nover 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerton of University: 1 ☐ Yes No Specify:	pecify Yes or No- pecify Yes or No- No- No- No- No- No- No- No- No- No-	14. Race - Ameri Black, White	
Baltimore, Maryland 21215-0036	d within 72 ho giene. r than "natu the Medical	Completed by	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired) Teacher	king	16b. Kind of Business/Ir	cation
land ?	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (<i>First, Middle, Las</i> Kermit A l	t) onzo Christian	18. Mother's Nam	e (First, Middle, N Ruby	Maiden Surname) Arlene Austin	
, Mary	and 2 shorealth and N n 27 is ma		19a. Informant's Name/Relationship Mrs. Sylvia Griffin K		alling Address (Street and Number or Flu 1421 Lake Christophe Driv	ral Route Number, e Virginia Be	City or Town, State, Zi each, Virginia 23	464
imore	permit. Pages 1 Department of H Important: If ite any injury or ot		20a Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Content of the Cont	Removal from State 20b. Place of Discemetery, c	rematory or other place) umbia Memorial Park	09/28/07	20c. Location - City or T Clarksville	own, State e, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	113 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	22. Name and Address of Facility Slack Funeral Home 3871 Old Columbia	e, P.A. Pike Ellicott	City, MD 21043	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons, quence of): b. Due to (or as a cons, quence of):	Hery Disease	or respiratory arre	est,	Approximate Interval Between Onset and Death Years Veurs
68760, <	rtificate be executed ng physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Years			
P.O. Box 68	Attending Physician: The law requires that the death certifica death. death. ector: After this certificate has been signed by the attending property the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 Months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		3□Ectopic pregnancy 5□ Other (specify)	23d. Date of deliv Month	very Day Year	
	quires that an signed build be det	þ	Part II. Other significant conditions	contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	the cause of death? obably 4 □Unknown	
or Vital Records,	ician: The law re certificate has bec ector, page 2 sho	Completed				24a. Was ar autops perforn 1∐ Yes 2	y prior to co	opsy findings available ompletion of cause of
<u> </u>	sician s certif lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 20 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	th (Check only one	e) ence 6 □Other <i>(Spec</i>	i6.1
on or	nding Physician: The th. : After this certificate ha funeral director, page	tion: To	27. Man er of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe ho		19)
Division	al or Atters after dea al Director	Certification:	3 Suicide 6 Could not l 4 Homicide determined		street, factory, office	28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C		hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu			
	To t To t	Σ	29b. Signature and title of certifier Borne	talino, 000	29c. License number 40040518		9d. Date signed (Month $9/2$	
	97		30. Name and address of person who	completed cause of death (Item 23a) (Typ	north Dr. Colu	unhia	9/24/5 Mo 210	U o
	Sta Regist		31. Date filed (Month, Day, Year)	32. Fogistrar's Signature	ALLE .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 0.2/AM September 22,200 Evelyn Frieda Uhden /Medical Center 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner DURNIE Glen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/30/1937 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. 1 ☐ M 2 🔀 F 216-34-0241 70 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 255 Asbury Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Maryland 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Brush Maker Glass 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred A. Wall Frederick Schuhly ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If item 27 is
any injury or other trau 255 Charles Uhden/Husband Asbury Road, Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veteran's Cem 09/26/07 Crownsville, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Suneral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner えてメ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? Yes No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 TYes 1 🔲 Inpatient ER/Qutpatient 3 □ DOA After this sompletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending Natural 5 Pending investigation 1 🗌 Yes death. 2 ☐ Acsident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my anising death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1AGADDA 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Physician Penciliised at above penciliised at Pencili	4a. Facility Name (If not institution, git The Johns Horos. 5. Social Security Number 6.		Vhite			Day Year	- 4		
Examiner Funeral Director	4a. Facility Name (If not institution, git The Johns Ho				EP temp	er 18,200	7 10:00		
Funeral Director	The Johns Horos. Social Security Number 6.			or Location of Death		c. County of Deal			
Director	Social Security Number 6.	oring Hospita	1 balti	more					
		Sex 7. Age (In yrs. las	t birthday) If Under 1 Yea		B. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Fore		
fied at tor	212-44- 6024	1 ⊠ M 2□F 62	Yrs.		DEC. 20,	1944	MD		
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물림 [유]							1 X Yes 2 □		
6 58	MD 10e. Street and Number	BAL	PIMORE 10f. Zip Code		100.0	Citizen of What Co	puntry?		
a or 28a-f a the notified Director							,		
r Items 23. Inher must Funeral	2317 E. LAFAYET	12. Was Decedent Ever in U.S.	21213 13. Was Decedent of	5 f Hispanic Origin? (Specuban, Mexican, Puerto R		USA 14. Race - Ame			
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b b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔼 N	lo Specify:		Specify: BI	ACK		
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item 27 is marked other than other traumatic event, the M To Be Comp	19a. Informant's Name/Relationship	1 11 1	19b. Mailing Address (Stre	et and Number or Rural	Route Number, Cit	y or Town, State, .	Zip Code)		
m 27 ner tr	FREDONIA E. WHIT			AFAYETTE AVI	E., BALTI	MORE, MD	21213		
	20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3	000	ce of Disposition (Name of netery, crematory or other p	nlace)	550	Location - City or DONN	IELL ST.		
Important; If any injury or once.	` 4 ☐ Donation 5 ☐ Other (Spec	ify)	BAYVIEW	09/26/	2007 BAI	TIMORE,	MD 21224		
Import any inj once.	21. Signature of Funeral Service Lice	nsee	22. Name and Add	dress of Facility WESI	EY CHAVI	S, JR. F	NRL. HM.		
트등점	23a. Pert1. Enter the disease, or con	P. Hunter		EASTERN AV		IMORE, M	D 21231 Approximate Interval Between		
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ed by the attending physician detached for use as the burial Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3 ☐ Ectopic pregnar			23d. Date of de Month	livery Day Year		
be o	Part II. Other significant conditions	contributing to death but not result	ing in the underlying cause	given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 No 3 ☐ Pro		o the cause of death robably 4 _Unkn		
cate has been si page 2 should to Completed		7	/		24a. Was an autopsy performed	prior to	utopsy findings avail completion of cause		
cate Pag					1□ Yes 2	No 1 ☐ Ye	s 2 No		
Be Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death Other:		THE RES	-		
this of	1 Yes 2 No	1 Inpatient 212 E	NOutpatient 3 DOA	4 Nursing Hom	e 5 Residence 8d. Describe how in		ecify)		
After uner	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	Injury V	Vork? □ Yes 2 □ No	DG. Describe now ii	ijary coodinod			
To the Funeral Director After this certificate has completely filled in by the funeral director, page 2 Medical Certification; To Be Comp	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be con Blanc of Injury At home		8f. Location (Street City or Town, St		tural Route Number,			
mpletely filler									
Me Me	29b. Signature and title of certifier		29c. Lice	ense number	29d.	Date signed (Mon	th, Day, Year)		
- ō →	1/1/2	or (Mo	200	5-000	40	Dtonihas	18,000		
	30. Name and address of person wh	completed cause of death (Item 3	23a) (Type, Print) OIFE Street		00	NIGINIOG!	.01200		
)	Come V blen	(acc North W	also exam	Daldinar	e Miner	land	21297		

DHMH 17 Rev 1/2001

Piease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month 6:45PM **Physician** Wissmann 2007 足厂 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes HOSDITCH 0 11, more 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X**M 2□F 83 Months Days 1924 27, Director 281-18-8120 Ohio Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4709 Ruby Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 K Yes 2 1 No
If Yes, Give
Year or Dates: 1943-77 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, tems! 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Chief Accounting Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willaim C. Wissmann Antoinette M. Englert Department of Health and Important: If Item 27 is manany injury or other traumatong. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth J. Wissmann/Wife 4709 Ruby Avenue Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Arlington 1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 12-4-2007 Arlington, VA. Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service/License 23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician etastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran and Due to (or as a consequence of): cate has been signed by the attending physician a page 2 should be detached for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an certificate has 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 ☐ Accident al or Attendi after death. I Director: A 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappier stated. (Check only To the I within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and lifte of certifi person who completed cause of death (Item 23a) (Type, Print) 30. Name and address. m 31. Date filed (Mongs State 2007 Registrar

07-07451 Mark Waring Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lark Waring	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2007 3 1	12								
Physician Medical Examine	Registrar 1. Decedent's Name (First, Middle,Last) Mark Timothy Waring 2. Date of Death Month Day Year September 24, 2007 3. Time of Death 0920 hrs									
wedical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)	oreign								
Birector	Usual Residence of Decedent									
ow any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City L Maryland Baltimore 1 X Yes 2									
th the Maryland 23a or 28a-f show any notified at once.										
the M 3a or 2 otified										
72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho all Examiner must be notified at once losted by Ermanal Director	11. Marital Status 1	1 × 1.								
urs afte	or Dates: 1. Specific of the State of the S									
5-0036 led within 72 hours al Hygiene other than "natural the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programmer University of Mary at Baltimore	land								
2121 uld be fii Mental I marked										
L sho	Charles F. Waring Father 208 South Paradise Avenue; Catonsville, MD 2122	8								
Ore, M	1 Burial 2 X Cremation 3 Removal from State crematory or other place)									
Baltimore, permit. Pages 1 as Department of He. Important: If ite	4 Donation 5 Other Specify: Metro Crematory 9/26/2007 Catonsville, Maryl 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling, Ashton Schwab Witzke	.and								
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate In	terval								
Physician /Medical	failure. List only one cause on each line. Death Death									
aminer	Immediate Cause (Final disease or condition resulting in death) a. CITORIC attorious									
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
ecuted and and transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
10, e be execut ysician and burial - tra	X UNPENDED AMENDED PII, 27, perME, g872, 10/4/07 TT									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the property of the prope	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	ır								
P.O. B as that the degree by the detached it										
ls, P.	Wilson's Disease 1 Yes 2 No 3 Probably 4 ✔ Unkr									
Division of Vital Records, P.C. tal or Attending Physician: The law requires that is after death. The law requires that in the law requires that in Director: After this certificate has been signed limited by the funeral director, page 2 should be determented by the funeral director, page 2 should be determined.	autopsy prior to completion of cause death? 1 ✓ Yes 2 No 1 ✓ Yes 2 t	se of								
Vital ysician:	25. Was case referred to medical 20. Flace of Death (Check only one) examiner? Hospital: 4 Innation 2 FR/Outpatient 3 DO4 Other; Nursing Home 5 Residence 6 V Other: Scene									
fing Physi										
Division of spiral or Attending nous after death nous a free death fulled in by the fune	Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State)	r, City								
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the										
To the He within 24 To the Fu completel	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	O.C.M.E. September 25, 2007									
4	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Sta	e 31. Date filed (Month, Day, Year) 32/ Registrar's Signature									
Registr	TOLIA (LOUI)									

cords, P.O. Box 68760,		Baltimore, Maryland 21215-0036
w requires that the death certificate be executed	Phy /M Ex:	permit, Pages 1 and 2 should be filed within 72 hours after death with the
been signed by the attending physician and	/sid lec am	Department of health and wenter hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2.
should be detached for use as the burlal-transit	ci lic in	any injury or other traumatic event the Medical Evaminer must be or

	L.		For State Registrar		State	of Maryla	-	artment of F <i>rtificate of</i>		i Mentai Hy	/giene, Reg. No.	7 4 1 1 4 1	31122
			Decedent's Na	me (First, Middle	, Last)					2. Date of D	eath		3. Time of Death
	Physici		MAI	2 TH A		Wi	ELKER			Month SEPTE	Day MS ESC		7 1135 A M
	/Medic				, give street and no	umber)		4b. City, Town, o	r Location of De			County of Death	
7			WORTH	+ WEST	HOSPITAL			RAND	Aus Town			BATIME	NEF
	Funeral		5. Social Security		6. Sex 1 ☐ M 2 ☐ ₹	7. Age (In yi	s. last birthday)	If Under 1 Year Months Days	If Under 24 H		rth ay, Yea <i>r)</i>	9. Birth Coa	nplace (State or Foreign Intry)
4	Director		185-22-39			77	, Yrs.			Oct 6,	1929		PA
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Meal Examiner must be notified at	_	Usual Residence 10a. State	10b. County		10c. (City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 🔼 Ŋo
	e Ma 3a-f s	Director	MD	Carroll		Wes	tminster						
	or 28	Dire	10e. Street and N	lumber				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	ath w	ral	595 01d N		r Pike		11.6		157	/O!f . V Al	. 1	USA 14. Race - Amer	ican Indian
	er de Items	Funeral	11. Marital Status	i urried 2□ Marr	Armed F	cedent Ever in forces? 2 ∏∜X o	0.5.	Was Decedent of H If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	0-	Black, White	
36	rs aff	by F		4 ☐ Divorced	If Yes, G Year or	iive		1 ☐ Yes 21☑ No	Specify:			Specify: W	hite
5-0036	2 hou atura	pe le		15. Decedent	's Education st grade completed		16a. Dece	dent's Usual Occup	pation	antila a	16b. Kir	nd of Business/I	ndustry
215	hin 7; e. an "n Medi	Completed	Elementary/Se) (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of w d)	vorking			
2121	d wit	Son	12		2		Ac	count Admi				Bankin	g
nd	be file	Be (17. Father's Nam	e (First, Middle,	Last)					ame (First, Middle	,	Surname)	
<u>yla</u>	Meni Meni arke	မ	George R.				1			ny Hoagland			
Maryland	2 sh and Is m	19a. Informant's Name/Relationship (Type. Print) Robert Kurland Son 19b. Mailing Address (Street and Number or Rui 595 01d New Windsor Pike, V 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)											ip Code)
	1 and Health									Date		cation - City or	Town, State
Baltimore,	permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 DeBurial		3 □Removal from pecify)	1 State	cemetery, cre orefield		F	29, 2007		itage, PA	
Balt	permit, Departr Imports any Inj	21. Signature of Juneral Service Licersee 22. Name and Address of Facility Fink Funeral Home, P 426 Crain Hwy S, Gle 23a. Part1. Enter the disease, or com, cations that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. Littonly one cause on each line.										21061	
			23a. Part1. Ente	r the disease, or	com vications that	caused the de	ath. Do not en	ter the mode of dyi	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Caus disease or condi	e (Final	0			9					Onset and Death
1	/Medical		resulting in death		Due to	(or as a ns	equence of):	Egackaria					
	Examiner		Sequentially list	conditions.	b	chron	i obst	buchin pr	done	distan			
Pite	p sit	ine	Sequentially list if any, leading to cause. Enter Un Cause (Disease	immediate derlying	Due to	o (or as a cons	equence of):	,		-			
(and -trans	Examiner	that initiated ever resulting in death	าเร	C	(or as a cons	equence of):			·			
60,	be ex ician burlal	E E			20010	(pr as a cons	equentee ory.						
68760,	ficate be executed g physician and is the burlal-transit	edical			d								
		/Me	IF FEMALE:			2	23d. Date of deli	verv					
Вох	death cert e attending d for use a	Physician/M		23c. If yes, outcome pringmant in the past 12 months?								Month	Day Year
P.O.		nysi	9 Unknov		9□Unk	nown							
	The law requires that the te has been signed by this age 2 should be detache	by P	Part II. Other sign	nificant condition	ons contributing to	death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
ğ	w require been slg should b	edt								- 1	Yes 2	□ No 3□ Pro	bably 4 🔀 Inknown
000	aw requ is been 2 should	Completed								24a. Wa	s an	24b. Were au	topsy findings available ompletion of cause of
Ä	The law ate has I	mo									formed?	death?	210 No
ita	ysician: The is certificate hadirector, page	Be	25. Was case ref	erred to medical						eath (Check only	one)		
or Vital Records,	Physician: this certific ral director,	T0	1 ☐ Yes 2				☐ ER/Outpatie		4 🗀 Nursing	Home 5□Res			eify)
n o	iling Phys I. After this funeral di		27. Manner of De	5 Pendin	g (Mo	e of Injury nth, Day Year)	28b. Time o	Wor		28d. Describe	how injur	y occurred	
isio	Attending r death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could r	not be	o of injune - At	home farm st	M 1 □	Yes 2 □ No	28f Location	(Street an	d Number or Ru	ral Route Number,
Division	al or A	Certification:	4 ☐ Homicide	determ	ined 200. Flac	ding, etc. (Spe	cify)	eet, factory, office		City or To	own, State,)	rai riodie Nambei,
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Note of the determined 2 Sec. Place of Injury - At home, farm, street, factory, office 2 Sec. Injury at Work? 1 Yes 2 No 2 Sec. Injury at Work? 1													
	To th within To th сопр	Me	29b. Signature a	nd title of certifie				29c. Licens	se number		29d. Dat	te signed (Month	n, Day, Year)
	,		10	Of h sex	-in man			Doc	5 9 7 36		Ser	atember	25, 2007
	12		30. Name and ed	dress of person	who completed cau	use of death (It	em 23a) (Type,	Print)					
	V		DEBORA			ZPATRAL		. MURT	Hw 57 14	DIPITAL	54	01000	OURT POAP
	Sta Registr		31. Date filed (M		2007	Registrar's Sig	nature	ede					

dward Watkins	1- For State	State of Maryland	/ Department of Certificate of		Mental Hyg	giene Reg. No	. 200	07 3112		
Physician/						2. Date of Death		3. Time of Death 2228 hrs		
Medical Examine	EDWARD	J. WATKINS	Ś	4b. City, Town, or Le		Month Day September 23	4c. County of Dea			
	4a. Facility Name (if not ins Sinai Hospital	stitution, give street and number	r)	Baltimore		1.10=	40. County of Doa			
Funeral	5. Social Security Number	18/1/ 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (MI	M/DD/YYYY) 9. B	irthplace (State or		
Director	× =	1 M 2 F	52 Yrs	Months Days	Hours Min.	Aug, 21,	, 1955 Fore	country) MD		
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Deced		10c. City, Town or Loca	tion				10d. Inside City Limits		
1 10w any	11	ounty	BALTIMO					1 Yes 2 No		
be Maryland or 28a-f show fied at once.	10e. Street and Number		DALIMO	10f. Zip Code	. 105	10g. C	Citizen of What Co	untry?		
the Maryland a or 28a-f sh tiffed at once	3019 RITHE	WOOD AVE		2/2/	15.	UA	IITED S	STATES		
death with the Maryland or items 23a or 28a-f sho must be notified at once.	11. Marital Status	12. Was Deceder		as Decedent of Hisp Yes, specify Cuban,			14. Race - Ame White, etc.	erican Indian, Black,		
	1 Never Married 2	1 Yes 2	2 No	Yes 2 No			Specify: B	INOK		
hours after natural", e Examiner.	3 Widowed 4	Divorced If Yes, Give Year or Dates:	ompleted) 16a. Decede	nt's Usual Occupation	on (Give kind of wo		. Kind of Busines			
. 2	Elementary/Secondary (r 5+) during n	nost of working life. I	DO NOT use retire	ed)				
15-0036 filed within 72 hours at Hygiene. d other than "natural, the Medical Examin, the Completed by	10		1 PR	INTER		First, Middle, Maide	LNDUST	RIAL		
		Middle, Last)		11	ELEAN			MIKINS		
2121; could be fil d Mental Is s marked tic event,		lationship (Type, Print)	19b. Mailir	ng Address (Street						
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental ant: If item 27 is mayked or other traumatic event, To Be	ELEANOR	MOORE	3019		EWOOD	AVE, B	ALTO. N	D 2/2/5 or Town, State		
re, land s land freal frient ra	20a. Method of Disposition	mation 3 Removal from S	20b. Place of Dispo crematory or o		•					
Baltimore, permit Pages I an Department of Her Important: If ite	4 Donation 5 Ot	her Specify:	BAYVIE	W CREMA	TORY 10 1	2007	DUNDAL	K,MD.		
Baltimor permit Pages Department of Important: If injury or othe	21. Signature of Funeral S	Service Licensee	22.	HAPEL 1	(-20 A/	ILLER'S	METRO NAY BA	TO MA 2/2/A		
Physician	23a. Part I. Enter the disea	ase, or complications that cause	ed the death. Do not enter	the mode of dying, s	such as cardiac or	respiratory arrest, s	shock, or heart	proximate Interval Between Onset and		
Medical	failure. List only one Immediate Cause (Final di	Compliant	ions of chronic	alcohol us	e			Death		
aminer	or condition resulting in de		sequence of):		٥,٠					
<u>.</u>	Sequentially list conditions if any, leading to immediat	te Due to (or as a con	sequence of):							
ed nsit	cause. Enter Underlying ((Disease or injury that initi	ated C.	sequence of):							
vecuted n and ransit	events resulting in death)	d								
ciar rial	X UNPENDED	AMENDED 27,	perME,g872, 10/	4/07 TT						
		23c. If yes, outc	ome of pregnancy	etal death 3	Ectopic pregnar		23d. Date of deliv Month	ery Day Year		
box 6876. The death certificate by the attending phyche of or use as the Physician/M	past 12 months?	4 Pregnant	A P C do eth	Other (Specify)		<u> </u>				
Bo ne deat the at the at	1 Yes 2 No 9	Unknown 9 Unknown	-th but not condition in the	underlying cours of	von in Part I	23e Did tohac	co use contribute	to the cause of death?		
, P.O. E ires that the d signed by the detached d by Physical by P	\$	conditions contributing to dea	ath but not resulting in the	underlying cause gi	ven in Fait i.	1 Yes 2		robably 4 🗸 Unknown		
Records, 1 The law requires ficate has been sig., agge 2 should be						24a. Was an		autopsy findings available to completion of cause of		
COT law r e has b e 2 sh						autopsy performed		?		
tal Reccinan: The lay certificate ha ector, page 2		medical		26.Place	of Death (Check o		NO I	.00		
of Vital Records, ng Physician: The law require Nfer this certificate has been si nneral director, page 2 should b		Hospital: 1 Inpa	tient 2 🗸 ER/Outpatier	nt 3 DOA	Other Nursing	g Home 5 Res	sidence 6 Ot	her:		
fing Phy After t funeral		28a. Date of Ir (Month, Day	njury 28b. Time of y,Year)		´ _ I	28d. Describe how	injury occurred			
sion strend death ctor: y the f	2 Accident	Pending Investigation	Albama farm at		es 2 No	28f Location (Street	et and Number or	Rural Route Number, City		
Division of Vital Records, P.O. Box 68761 for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/M.	3 Suicide 6	Could not be determined (Specify)	Injury - At home, farm, str	eet, factory, office be	illullig, etc.	or Town, State		,		
Hospit 14 hour rely fill										
To the Hos within 24 h To the Fun completely	one) 2 Medic	and manner state	xamination and/or investig d.							
		7. 1	MA	29c. License O.C.M			eptember 24			
	Donna			0.0.1	VI. limi			,		
	30. Name and address of Donna M. Vincer	person who completed cause on ti, MD Assistant Med	dical Examiner 11	1 Penn Street,	Baltimore, MI	D 21201				
Stat			trar's Signature	all)						
Registra	SEP 2	COUL Jackson	and he had							

		1 _ State	State of Maryland	-		of Health and Notes of Death		ene g. No 2 N N T	7 21121		
	,	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
Physic			Vounc Ir				Month Septembe	Day Yea	7 3:05 A M		
/Medi		Frederick William 4a. Facility Name (If not institution, give sti			4b. City, Toy	vn, or Location of Death		4c. County of De			
Exami	ner	9902 Richlyn l				erry Hall		Ra1t	imore		
Funaval		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth	I o B	irthplece (State or Foreign Country)		
Funeral Director		215-24-9516 ^{1XI}	M 2□F 80	Yrs.	Months D	ays Hours Min.	(Month, Day, April 10	1927	Maryland		
		Usuel Residence of Decedent									
ylan		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
Ma-fa	to	Maryland Baltim	ore		Perry	Ha11			1 ☐ Yes 21 No		
in the	Director	10e. Street and Number			10f. Zip Co	de	10	og. Citizen of What	Country?		
238 (238)		9902 Richlyn Drive				21128		U. S.	. A.		
dea	Funeral	11. Marital Status	2. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Deceden	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- Dican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.		
or it	FL	1 Never Married 2 Married	1 X Yes 2 □ No 1945 If Yes, Give		1□Yes 2🏋	No Specify:		Specify:			
ural.	d by	3 Widowed 4 Divorced	Year or Dates: 1946					1Ch Kind of Busines	White		
72 1	Completed	15. Decedent's Educa (Specify only highest grade	ntion completed)	(Give	dent's Usual C kind of work o DO NOT use i	one during most of wor		16b. Kind of Busines	ss/industry		
Mithin Mithin	ш	Elementary/Secondary (0-12)	College (1-4or 5+)					Ra1+-	imore County		
Hygie Hygie Ther t		12 17. Father's Name (First, Middle, Last)		<u>I</u>	olice	Officer 18. Mother's Nam	ne (First, Middle, M		Lillote Country		
Lat yidnic Z IZ IS-COOSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itame 23s or 28a-f ahow surmatic event, the Medical Experience runt be notified at	Be		~ C**				lia Schum				
hould d Me mark matic	2	Frederick W. Young		19h Mailir	ng Address /S	treet and Number or Ru			. Zip Code)		
12 sl h an 7 le r traur						n Dr., Per					
Healt Healt em 2 ther		Catherine J. Young 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of !	The second secon	20c. Location - City			
S E I		1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State Zio	emetery, crer n Evan	matory or other	Luth.	2/0007				
mit. Pages partment of portant: If It y injury or o		*4 □ Donation 5 □ Other (Specify)			Cemeter	ddress of Facility Sc			Run, Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural; or Itame 23a or 28a-f ahov any injury or other traumatic event; the Medical Exertational be polificed an once.		21. Signature of Funeral Service Licenses	Pine be			air Rd., N					
		23a. Part1. Enter the disease, or complication	ations that caused the death						Approximate		
	н	shock, or heart failure. List only one	cause on each line.				7		Onset and Death		
Physician		Immediate Cause (Final disease or condition resulting in death)	Arteriosch		- Chi	LioVIDOU)A	1 deple	-20	NONE		
/Medical Examiner		Due to (or as a consequence of):									
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							
) be tist	nine	cause. Enter Underlying Cause (Disease or injury	000 10 (01 00 00 00 00 00 00 00 00 00 00 00 00 0								
and and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):							
The COLIUS, T.O. DOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE										
phys phys s the	dlcal	d.									
Geath certific sattending p	Physiclan/Me	IF FEMALE: 23	c. If yes, outcome of pregna	incy				23d. Date of	delivery		
Bath attent for u	clan	in the past 12 months?	1 Live birth 2 Fetal	death 3	∃Ectopic preg ∃ Other <i>(spec</i> i			Month	Day Year		
the d	ysi	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown			//					
uires that the dent signed by the a		Part II. Other significant conditions cont	ributing to death but not resi	ulting in the u	inderlying cau:	se given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?		
uires ti signe Id be c	d by						1 □ Y€	s 2.10 No 3□	Probably 4 Unknown		
w require	Completed						24a. Was a	n 24b. Were	autopsy findings available		
ne far has ge 2	E D						autops perforr	ned? death	to completion of cause of		
	CO	25. Was case referred medical				OC Place of De			′es 2□ No		
OI VICE Physicien: rthis certific ral director,	o Be	examiner?	ospital: 1 Inpatient 2	ER/Outpaties	nt 3 DOA	Other	th (Check only on	ence 6 Other (S	inecity)		
rate By C	-	27. Man or of Death	28a, Date of Injury	28b. Time o		Injury at		ow injury occurred	роспу		
Afte fune	ţ	1 Datural 5 Pending	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No					
or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, st	reet, factory, o	ffice	28f. Location (St	reet and Number or	Rural Route Number,		
after Dire		4 Homicide	building, etc. (Specify	y)			City or Town	n, State)			
spital ours veral	O	29a. Certifier 1 Certifying Physi	ician: To the best of my kno	wledge, deat	h occurred at	the time, date and place	, and due to the ca	ause(s) and manner	as stated.		
24 h 9 Fur etely	edical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in	my opinion, death occu	irred at the time, d	ate and place, and	due to the cause(s)		
T € S 20h Signature and title of entitle r								9d. Date signed (M	onth, Day, Year)		
P ≤ F Ö		* alder An	so ky		10	2017758	5	entry ber	26, 2007		
		0, ame and address of person who cor	npleted cause of death (Item	n 23a) (Tvoe	Print).	-131-3	10	/	011 21-2		
10		U. ame and address of person who can	> Hes' Sol	o Ver	49	y Cotalul	01910d. 1	morture,	26, 2007 Md, 2128		
	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	iture,	20 a	7					
Regis		SEP 2 7 20	U/ Designed .	15 /4							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Geotember **Physician** DEAN IKENNA ANABARAONYE 3:42 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL T.ANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ∏ M 2□ F MARYLAND 216-51-1502 9 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 Yes 2 No Directo MD PRINCE GEORGE'S LANHAM the I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6605 MANTON WAY Funeral 20706 USA Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: BLACK Specify. Completed by 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during mòst of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED NONE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) is marked of traumatic ROMANUS ANABARAONYE BLESSING ANABARAONYE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other trains ROMANUS ANABARAONYE/FATHER 6605 MANTON WAY LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/15/2007 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME nugen 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cause many not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2V No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1□ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 21 No or Attending Physician: 25. Was case referred to medical examiner? director å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 27. May er of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Ite

n 23a) (Type, Print)

Hector E. Knox Jr. M.D. 8118 Good Luck Rd Lanham, Maryland 20706

32. Registrar's Signature

29c. License number

29d. Pate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician September 10, 2007 Battle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 X 1 F 577-72-7066 55 August 10, 1952 North Carolina **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 4001 Carozza Court 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 ▼No Specify Black. Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ages 1 and 2 should be filed went of Health and Mental Hygier It: If Item 27 is marked other thy or other traumatic event, the Bus Driver Trainer vear Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene McMillian, Jr. Laura Wright 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4001 Carozza Ct. Temple Hills MD 20748 James Battle - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Resurrection Cemetery Sept 15, 2007 Clinton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road NE Washington, DC 20019 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, of heart failure. List only one cause on each line. Immediate Ca e (Final Myocardial Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a cons y uence of): Examiner Heroscleron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Col 24a. Was an autonsy 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to mexaminer? certificate Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Fun 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P0037066 09-11-2007

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/88 0 x 0n/14/1 Rd# 70)

Uche chi 7. 0 94ight 094, m-D 0 x 0n 4ill, mD 20745

97-06866 Jasmine Borum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31127

		- For State		Cen	tificate of	Death					Reg. No.			
Physicia	ın/	Registrar 1. Decedent's Name (First, Middl Jasmin A.								Date of De Month Septemb	Day er 4, 200		08	me of Death 819 hrs
		4a. Facility Name (if not institution 6128 Macbeth Drive	on, give street and numb	er)	4	b. City, Tow Baltimo		cation of		**.	4c. C	ounty of D	eath	
Funeral		5. Social Security Number	-	Age (In yrs. Ia	7	If Under	1 Year Days	If Under Hours	24Hrs.		Birth(MM/DE	1 _F	J. Birthplac oreign Country)	e (State or
Director		214-27-3706	1 M 2 XF	1	.7 Yrs.			Α.		IVOV .	21 170			
· - · · · · · · · · · · · · · · · · · ·		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Locati	on							10d.	Inside City Limits
ow any		MD			Baltim	ore							1	Yes 2 XiNo
Maryland 28a-f show d at once.	ctor	10e. Street and Number				10f. Zip C	ode			31.5	10g. Citize			
5-0036 led within 72 hours after death with the Maryland lygiene other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once,	Dire	6128 MacBet	h Dr 1st	Floor				239		· .		US		
nwith	uneral	11. Marital Status	12. Was Deced		S. 13. Wa	s Decedent es, specify	of Hispa Cuban, I	anic Origi Mexican,	in? (Spec	cify Yes or I	No- 14		American fo	ndian, Black;
death or iten	Fun		1 Yes	2 XNo			_				Specify: Black			ck
after	<u>_</u>	L., al	vorced If Yes, Give Yeer or Dates:	assembled)	16a. Deceden	Yes 2 3			ind of wo	ork done			ness/Indus	try
hours fnatu Exa		15. Decedent's Education (Spe Elementary/Secondary (0-12)			during m	ost of worki	ng life. I	OO NOT	use retire	(pd)				carata Carder Carre
5036 within 72 hours after the "natural", ret than "natural", Medical Exa. there	Completed	10	, Gomego (Casl			•				's D	∋TI
		17. Father's Name (First, Middle Maurice Robin	e, Last) NSON				18			First, Middle Borum	e, Maiden S l	urname)		,
2121 ould be fil Mental I marked ic event,	To Be	19a. Informant's Name/Relation	4		. 19b. Mailing	g Address	(Street	and Num	ber or Ru	ural Route N	lumber, City	or Town;	State,:Zip	Code), with
MD 2 d 2 shou th and 1 d 27 is r	-	Maurice Robins			CMR			2534	AF	O AE	091			
e, N and A Health item	grade 1	20a. Method of Disposition			Place of Dispos crematory or ot	sition (Name	of cem	etery,	09/1	Date 2/200	20c. Lo	ocation - C	City or Tow	n, State
ages ant of a lt.		1 Burial 2 Crematic		II State	estmins		emet	erv	05/1	.2, 200		stmir	nster	, MD
Baltimore permit. Pages 1 a Department of He Important: If it	٠	4 Donation 5 Other S 21. Signature of Funeral Service		170	2374	Nameters A	Func	of Facility	Home	and	Chape	1, P.	.A.	
Balt permit Depart Impor injury		MA			141	2 Was	hino	rton	Road	l Wes	tmins	ter,	MD	21157 pproximate Interval
^o hysician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that cause on each line.	used the death	. Do not enter t	the mode of	dying, s	such as c	ardiac or	respiratory	arrest, snoc	K, or near	È.	Between Onset and Death
Medical. _xaminer	9.8	Immediate Cause (Final diseas											-	Death
		or condition resulting in death)	Due to (or as a c	onsequence o	ot):				".					
	er	Sequentially list conditions, — if any, leading to immediate	Due to (or as,a.c	consequence	of):			-	W	45 E	-1	.		- H H H H
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760, ficate be g physici the buri	Med	IF FEMALE:	ate a	utcome of pre	gnancy							. Date of d	delivery Day	Year
687 ertific		23b. Was decedent pregnant in past 12 months?	I LIVE DI	th int at time of d		etal death		iEctopi	c pregnai	ncy		Month	Day	· car
Box 68's death certification attending	Physicia	1 Yes 2 No 9 🗸 U	7		3 0	Tilel (Open	y/							
O. Bo tr the de 1 by the tached f	돈	Part II. Other significant cond	ditions contributing to	death but not	resulting in the	underlying	cause g	iven in Pa	art I.					cause of death?
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rds requi	e										utopsy	pr	rior to com	sy findings available pletion of cause of
eco he law ite has	Completed										erformed? es 2 N		eath? Yes	2 No
Vital Records, hysician: The law requir this certificate has been s il director, page 2 should	Be C	25. Was case referred to medi				2		of Death						
Vita hysicia this ce	<u>@</u>	examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatier		٠,٠	Other ₄		g Home 5			Other: So	ene
1 of \ding Phy L. After the		27. Manner of Death 1 Natural 5 Pe	28a. Date Month FOUND	of Injury Day,Year)	28b. Time of FOUND:	f Injury 2		ryatWor Yes 2 ✔	_	Subject s	ribe how inju shot	ily occurre	- u	
tendi death.] ig	2 Accident	Sep 4. 2	007	0814 hrs home, farm, str					28f Locati	on (Street a	nd Numbe	er or Rural	Route Number, City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Co	ould not be		nome, tarrii, str se / Rowho		, onice b	dilulig, e	, ic.	or Tov 6128 Mac	vn, State) beth Drive	, Baltimo	re, MD	,
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			Blueleine To the hee	of my knowle	dae death occ	urred at the	time, da	ate and p	lace, and	due to the	cause(s) an	id manner	as stated.	
the H nin 24 the Fu	Medical	(Check only one) 2 Medical E	xaminer:On the basis of	of examination	and/or investig	ation, in my	opinion	, death o	ccurred a	at the time, o	date and pla	ice, and di	ue to the c	ause(s)
To To To	≥	29b. Signeture and title of cert	and manner si tifier	ated.		290	. Licens	e numbe	r			•	•	, Day, Year)
N		(ny sc	Ha	200	Lor	/	O.C.	M.E.			Sep	tember	5, 2007	,
WIL		30. Name and address of pers	son who completed caus	se of death (Ite	em 23a)		_							
6	ĺ		Assistant Medical		111 Penr	Street, I	Baltim	ore, M	D 2120)1				
	State			gistrar's Signa	ature									
Regi		SEP 1	4 2007	Men .	A B	2042								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Blanche Bolti September 10,2007 12:10A. [™] 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number, Hillhøven Assisted Lvg. Nursing & Rehab Center Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Dec. 24, 1910 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 ☐ M 2 💢 F Washington,DC 579-48-5625 96 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Adelphi 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 Powder Mill Road 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No White Specify. Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) File Clerk private (unk) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Giordano Anna Goyhonne Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Carter -Sun Trust Bank Rep. CSRIC 5104 P.O. Box 26150 Richmond, Va. 23260 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥ Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 9/13/2007 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licept Bonard V. Borgwardt Funeral Home, PA 4400 Powder Miĭl Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 years Immediate Cause (Final Dementia resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or nighry that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I∐Yes 2 Xio 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Colon Cancer; Paget's Disease 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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items 23a

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permit. Pages 1 and 2 should be men which the partment of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the M

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar by the a þ signed b certificate has tirector, page 2 s After s after death.

I Director: A
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To the Funeral Dir

Examine Completed by Physician/Medical Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

the

Division or Vital Records, P.O. Box 68760

									24a. Was an autopsy performed? 1□ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No	
25. Was case referred	to medical						26.	Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 No		Hospital	1 □ Inpatient 2 □] ER/Outpatient	3 🗆	DOA	Other: 4	Nursing H	ome 5 Residence	6 ☐Other (Specify)	
27. Manner of Death Natural 5 Accident	☐ Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	1	Injury at Work? 1 □ Yes	2 □ No	28d. Describe how injur	ry occurred	
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1	Certifying Ph	ysiclan:	To the best of my kn	owledge, death	occurr	ed at tl	he time, da	ate and place	, and due to the cause(s) and manner as stated.	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

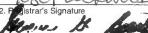
29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Mont)



			1 - State of State of Registrer	Maryland / Depa <i>Cei</i>	artment of F	lealth and M <i>Death</i>		en2007	31129
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Rachel Ellen Gresser Bake	r				2, 2007	0600 ^M
	Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or	Location of Death		4c. County of Death	n
		4	Layhill Center			Spring		Montgome	
	Funeral		1□M 200 E	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,	Year) Col	nplace (State or Foreign untry)
	Director		214-70-3340 Usual Residence of Decedent	51 Yrs.			FEB 17,	1956 D.C	
	land		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many	ō	Maryland Mantagnary	Cd 1 C-					1 ☐ Yes 2 🛣 No
	28a	Director	Maryland Montgomery 10e. Street and Number	Silver S	10f. Zip Code		10	g. Citizen of What Co	untry?
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	ms 2	Funeral	11 Marital Status 12. Was Decede	ent Ever in U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto I		14. Race - Amer	ncan Indian,
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8	ral', c	by	3 ☐ Widowed 4 🏋 Divorced If Yes, Give Year or Date	98:	1 ☐ Yes 2 🛣 No	Specify:		Specify: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show ther then "natural", or items 23a or 28a-1 show ont, the Medical Examinat must be multied at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of workii	1	6b. Kind of Business/I	ndustry
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	led w lygiel her tl		2	Entre	epreneur			Art	
Maryland	be fi	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
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<u>a</u>	d 2 st h and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Z	
	1 and Health em 2		Tina Baker/Daughter 20a. Method of Disposition	20b. Place of Dispo	Castle	Fown, State			
Baltimore,	nt of	5	1 ☐ Burial 2 X Cremation 3 ☐ Removal from St		natory or other plac CE	(e)	(2007		
텵	it. Partme		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service to have	Crematory	y. Inc.	3/1/	/2007	Beltsville	MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar insulate notified an once.		for flath	M00956 71	nibadeau 33 Gist A	Mortuary Ne., LL,	Service, Silver S	P.A. pring, MD	20910
			23a. Part Enter Me disease, or complications that cau shack, or heart failure. List only one cause on each	sed the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final	re to Thrive	2				Onset and Death 1 Month
	/Medical		resulting in death)	as a consequence of):	-				1 11011011
	Examiner		Sequentially list conditions, b						
	p #	Examiner	cause. Enter Underlying	as a nonsequence of):					
	ecute and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last C.				_		
8760,	cate be executed physician and the burial-transit	E	Due to (or	as a consequence of):				-	
87		dical	d						
9 ×	The law requires that the death certific lie has been signed by the attending rage 2 should be detached for use as	a	IF FEMALE: 23c. If yes, outco	me of pregnancy				004 Bake of deli	
Вох	atten for u	Physician/M	in the past 12 months?	n 2 🗆 Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deli	Day Y <i>e</i> ar
o.	the d	ysle	1 Yes 2 Mo 9 Unknown 9 Unknown		Journal (Specify)				
۹.	that led by deta		Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	luires ngn lid be	d by	Multiple Untreated Cancer	:s			1 □ Yes	s 2 □ No 3 □ Pro	bably 4 🖔 Unknown
Ö	w requir been s should	Completed	Clostridium Difficle Infe	oction			24a. Was an	24b. Were aut	topsy findings available
Re	The lav	m	Clostifulum Difficle Infe	CCIOII			autopsy	ed? prior to c death?	ompletion of cause of
Viita		CO	25. Was case referred to medical			OC Plans of Dooth		No 1 L Yes	2 ∑ No
5		OB	examiner?	atient 2 ER/Outpatien	t 30 DOA Oth	26. Place of Death		nce 6 Other (Spec	::A.1
o	ding Phys	\vdash	27. Manner of Death 28a. Date of	njury 28b. Time of	28c. Injun	vat 2	8d. Describe hov		eny)
Division of		딅	1 XNatural 5 □ Pending (Month, 2 □ Accident investigation	Day Year) Injury	Worl M 1 □	k? Yes 2 □ No			
NS.	Attending r death. ector: After by the fune	ertification;	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, str	eet, factory, office	2		eet and Number or Ru	ral Route Number,
ā	al or A s after al Direct	Cert	4 Homicide determined building	etc. (Specify)			City or Town,	Siate)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner	s of examination and/or in-	n occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	one) and manner 29b. Signature and titlenpt certifier	Stateu.	29c. License	e number	29	d. Date signed (Month	i, Day, Year)
	6 ≒ ≰ ⊣		W LANDELAN	A 1 D	D0064			9/12/2007	,
	1	i	20. Name and address of person who completed across	M. D				2,12,2007	=0.1-10
			30. Name and address of person who completed cause Saadia Husain, MD 3227 H	Bel Pre Rd.,		pring, MD	20906-	2423	
	Sta	te				. 07		<u></u>	
	Registr		SEL 1 3 5001	istrar's Signature	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day September **Physician** Howard Monroe Bailey 11 2007 11.40A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea. Nov. 21, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1**™** M 2□ F 214-44-4697 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 3160 Gracefield Road 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XDX'es 2 ☐ No If Yes, Give Year or Dates: 1941-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No SpecifWhite Specify: þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) US Dept. of Agriculture Program Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence H. Bailey Bertie P. Cole ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope D. Bailey/Wife 3122 Gracefield Road, #321, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 12, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final oficemia Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Delivium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-transit 41081 and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached the 9 Unknown 9 ☐ Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen Resipheral Vascular disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OH

State

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

2007

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2007

32. Resistrar's Signature

dovern

SEP 13

31. Date filed (Month, Day, Year)

LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD, SILVERSPRING, MD 2090L

			For		ryland /	Departn	nent of	Health and M	•		•	31131		
	Physici		1. Decedent's Name (First, Middle, La	Item 23a per Miam		2,900/1711/ Nevs,		Death	2. Date of Do Month	Day	Year 07	3. Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, give Baltimore VA 5. Social Security Number 6. S	e street and number) Medical	Cente (In yrs. last	24 J	City, Town,	or Location of Death		4c. (County of Death	lace (State or Foreign		
	Funeral Director			(XM 2□ F	81		nths Days		8. Date of Bi (Month, Di Feb • 2	0,192	6 Ma	ry land		
	2 should be filed within 72 hours after death with the Maryland and Mantel Hygiene. Is marked other than "natural", or frems 23a or 28a-f show aumatic event, the Madical Exacultant-sust be mutitled at	ctor	Virginia Berke		10c. City, To	own or Locatio		Waters				0d. Inside City Limits 1 Yes 2 No		
	ath with the 23s or 2	Funeral Director	10e. Street and Number 22 Emerson Dr.					5419			en of What Cour USA	itry?		
0	s after des	by Fune	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give	1946	_	Decedent of specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: 1,			
2	in 72 hour "natural" kulical Ex	Completed b	15. Decedent's Ed (Specify only highest gra	de completed)		Sa. Decedent's (Give kind life, DO N	Usual Occu of work done OT use retin	during most of work	ing	16b. Kin	d of Business/In			
7 - 7 N	s 1 and 2 should be filed within f Health and Mentel Hygiene. item 27 is marked other than other traumatic event, the Mentel Mentel free Mentel Mente		Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		Repai		e (First, Middle		nt Manut	facturer		
ylan	should be nd Mentel marked c matic eve	To Be	Kenneth William 19a. Informant's Name/Relationship (9b. Mailing Ad	dress (Stree	Nora Mo		enner		Code)		
≥ (1)	1 and 2 s Health ar em 27 is ther trau		Michael Bowers -			65 Carv	ers W	ay Falling		s, We		inia 25419		
	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	i		emeter	y \$ept.1		Shar		Maryland		
מ	permit. Depertr Importe eny Inju		21. Signature of Funeral Service Licer	how		425	S. Co	_ _	ue St.	Willi	amsport	, MD 21795		
F	Physician /Medical		23a. Part1. Enter the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line a. Due to (or as a	ic S	hock	mode of dy	psis	or respiratory a	urrest,		Approximate Interval Between Onset and Death		
ł	Examiner	ıer	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	b. Chronic Renal Failure Due to (or as a consequence of):										
ć	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):										
200	leath certificate b attending physic I for use as the b	Medica	IF FEMALE:	_ d.										
.0.	that the death or led by the attend detached for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal dea		pic pregnander (specify)	су		2	3d. Date of delive Month	ory Day Year		
r (epir	w requires that been signed b should be det	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	g in the underh	ying cause g	iven in Part I.		tobacco us		ne cause of death?		
		Completed							24a. Was auto perfi 1 ☐ Yes	psy ormed?	24b. Were auto prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of 2 No		
	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			0	26. Place of Deat	10.					
5	6 9 5	Η,	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Oate of Injury (Month, Day		Outpatient 3 D. Time of Injury	28c. Inju	4 Nursing Ho	28d. Describe		Other (Specif	v)		
CIAIS	after alter Direction by	Certification;	3 Suicide 6 Could not be determined		y - At home, (Specify)	farm, street, f	actory, office	,		Street and wn, State)	Number or Rura	l Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai (29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	ysician: To the best of niner: On the basis of a and manner state	xamination	dge, death occ and/or investig	urred at the lation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and	and manner as si place, and due to	ated. the cause(s)		
i	To the within 2 To the complet	ž	29b. Signature and title of certifier				29c. Licer	ise number		29d. Date	signed (Month,	Day, Year)		

SH 2+1

State Registrar

31. Date filed (Month, Day, Year) SEP 1.8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Shahzeb Munir

ION. Greene Street Baltimore MD 2 1201

0-636-469-9 9 115/07

MD

			For State Registrar	State of Ma	ryland / Dep Ce	partment of h partificate of	Health and N <i>Death</i>	nental Hyg	iene 2007	31132	
	Physici	an	Decedent's Name (First, Middle, La HARRY D. BERTI			-		2. Date of Deat Month 9	Day 2007	3. Time of Death 08:30 A M	
*	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			or Location of Death		4c. County of Dea	th	
	Funeral Director		Social Security Number 6. S		(In yrs. last birthda 69 Yrs.	BERL] // If Under 1 Year Months Days		8. Date of Birth (Month, Day, 2–10–19	WORCES (79.8) (138) DEI	thplace (State or Foreign punity) LAWARE	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	e Man Sa-feh	ctor	DELAWARE SUSSEX	ζ	FRANKI	ORD				1 ☐ Yes 2X No	
	with th	Dire	10e. Street and Number 36054 ZION CHURC	H BOVD		10f. Zip Code	F	1	0g. Citizen of What C	ountry?	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f ehow eny Injury or other treumatic event, the Medical Examinar must be notified at Once.	Funeral Director	11. Marital Status 1 ☑Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N			Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
, 00	hours a tural', c	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	16a Dec	1 ☐ Yes 2 🔀 No edent's Usual Occu			Specify: 1	WHITE	
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d 21	Hygier ther th		12 17. Father's Name (First, Middle, Last)	I	ABORER	18. Mother's Nam	e (First, Middle, M		KING PLANT	
Maryland	Aental Aental rked c	To Be	ALFRED A. BERTRA	AND			MINNI	E LYNCH			
lary	2 shoi and h is ma		19a. Informant's Name/Relationship (i				, City or Town, State,		
	1 and Health am 27		JEAN COOPER / SI 20a. Method of Dispesition	STER	20h Place of Die	nosition (Name of			DELAWARE 20c. Location - City o		
Baltimore,	Pages nent of ant: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 8 ☐ Other (Special		MELSONS HENLOPEN	ematory or other pla CAPE CREMATOR	^{сө)} Y 9-12-	-07	FRANKFORD	DELAWARE	
Balt	permit. Departr importi eny inju		21. Signature Furural Secure Licer	lukon	Ž	22. Name and Addre IELSON FUN 3 THATCHE	ERAL SERV	VICES, LTE). DELAWARE.	19945	
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each lin	е.	-	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
لم	/Medical		disease or condition resulting in death)		consequence of):	NCEL					
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	cuted	amln	Cause (Disease or injury that initiated events	с							
,0928	icate be executed physician and s the burial-transil	dical Examiner	resulting in death) Last	Due to (or as a	a consequence of):						
P.O. Box 6	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	у		23d. Date of de Month	blivery Day Year			
	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions of		23e. Did tobacco use contribute to the cause of o						
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ō	g Physer this eral di	다. 고	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	4 Nuising n		ence 6 Other (Sp ow injury occurred	ecify)	
Division of	eath. or: Aft	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n		M 1	Yes 2 No				
DIX	after d	Certification;	4 Homicide determined		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) Certifying Plants (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	me, date and place opinion, death occur	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)	
	withii To the	Σ	29b. Signature and title of certifier			29c. Licen			9d. Date signed (Mor	ith, Day, Year)	
e.			30. Name and address of person who	completed cause of de	eath (Item 23a) (Tun	a Print)	064120		9/11/07		
J	DN 10		ATIF. ZEESH	AN He	91thway	Drive	. 9733	. Berlin	N MD.	21811	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	had !			N MD.		
	negian	GI.	SEP 1 4	2007	we so	The same of the sa					

DHMH 17 Rev 1/2001

Bertrand, Harry

			For 1_ State	State of Marylan	d / Depa	artme	nt of Health and M	•	_	
			Registrar 1. Decedent's Name (First, Middle, Last,	1	Cei	rtifica	te of Death	Reg	3. No. 0 0 7	3. Time of Death
	Physicia	an		ozman					er 12, Žea	
7	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	r, Town, or Location of Death		4c. County of De	ath
1	and the second		Manokin Manor Nur				ncess Anne		Somers	
0	Funeral Director		217-05-0388	7. Age (In yrs.	last birthday) Yrs.	Month:	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 109/27/19	9. B 917 Ma	irthplace (State or Foreign Country) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Man Perfet	tor	MD Somers	et Pr	incess	Ann	e			1 X Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. 2	ip Code	10	g. Citizen of What	Country?
	e 23a	erai	11974 Edgehill T	errace 12. Was Decedent Ever in U.	S 12	Was Dec	21853	pacify Vas or No.	USA	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 20a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at 2009.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	Rican, etc.)	Black, WI	
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Us	ual Occupation		6b. Kind of Busines	ss/Industry
27	ithin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT	rork done during most of work use retired)	King		1 1
21	lied w lygier her th	ပိ	17. Father's Name (First, Middle, Last)	none	Food	Serv	ice Worker	ne (First, Middle, M.	County S	cnools
anc	d be fi	o Be	James A. Ray					Dayton	alderi Sumame)	
Baltimore, Maryland 21215-0036	should nd Me mark matic	ř	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Maili	ng Addre	ss (Street and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
Ž	alth a alth a 127 is		Mary Chamberlin/d	aughter	1114	7 St	ewart Neck Ro	ad, Princ	ess Anne	, MD 21853
ore	of He of He filter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. P	lace of Dispo emetery, crei	osition (A matory o	ame of other place)	Date 2	Oc. Location - City	or Town, State
<u><u>H</u></u>	Pag Iment tant: f		4 ☐ Donation 5 ☐ Other (Specify)	Be				5/2007 P	rincess	Anne, MD
Bail	Depar Depar mpor mpor no in		1. Signature of Fun-ral Servic- Licens	-			nd Address of Facility n Funeral Home			
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_	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
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Box	The law requires that the death certificate are been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		∃Ectopic	pregnancy		23d. Date of o	,
П	ne dea the att hed fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐ Unknown		Other			Month	Day Year
P.O.	hat th ed by detach	Phy	Part II. Other significant conditions co	ntributing to death but not res	ultina in the u	ınderiving	cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ďs,	uires signe Id be	d by		De mention				1 ☐ Yes	2 No 3	Probably 4 □Unknown
00	w requir s been si should	olete						24a. Was an	24b. Were	autopsy findings available to completion of cause of
Re	The la	Completed						autopsy perform	ed? death	to completion of cause of ? 'es 2 \sum No
ta	sian: artifica ctor. p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only one		
<u>ح</u> <	hysic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2				ome 5 Resider		рөсіfy)
uc	ding F	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Division of Vital Records,	Attending Physician: r death. sctor: After this certifications the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, st					Rural Route Number,
á	al or A s after al Dire	Serti	4 Homicide determined	building, etc. (Specif	у)			City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funerel Director Attenthis certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurrenvestigati	od at the time, date and place on, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the within 2. To the Complete	Me	29b. Signature and title of certifier			2	9c. License number		d. Date signed (Mo	
			NAM				D47094	1	9/13/0	フ
	1 EB		30. Name and address of person who co	NATERAN	11	Print)	5. DW 6 bec	v SA	NYBUM	M7 21804
	Sta Registr		31. Date filed (Month, Day, Year) SEP 14	32. Resistrar's Signa	iture	door	A)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 3:10 A <u>September</u> Florence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | August 100, 9. Birthplace (State or Foreign 1936 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🗑 F 577-56-8901 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Prince George's Hyattsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20783 4915 Eastern Avenue Apt. 417 Items 23a Be Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Year Elementary/Secondary (0-12) School Budget Analyst Government (Federal) of Health and Mental Hygie fitem 27 is marked other r other traumatic sysnt, in 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Henrietta (Unknown) Henry Randolph ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7529 Buchanan St. #155 Landover Hills, MD 20784 Cheryl Connor - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \$ept. 8, 2007 Clinton, MD 4 □Donation 5 □ Other (Specify) Lee's Crematory 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service License 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

12 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 3 T Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. ths To the within ? 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number September 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. James Lightfoot 7600 Carroll Ave. Takoma Park, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State SEP 1 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Sept. 12, 2007 12:00P M FRANCIS WILLIAM CHESLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Civista Medical Center Plata Charles La If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** CIOSER 14, 1922 Months Days MARYLAND 1 M 2 □ F 84 579-58-2944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County od other than "natural", or items 23a or 28a-f show event, the Medical Exa⊞lner must be notified at 1 ☐ Yes 2 ☐ No LA PLATA CHARLES Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number UNITED STATES 20646 7655 HAWTHORNE ROAD Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: BLACK Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8TH GRADE College (1-4or 5+) WELDER FEDERAL GOVERNMENT Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental JANE GREENE CHESLEY HENRY W. CHESLEY မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3726 13TH STREET, CHESAPEAKE BEACH, MARYLAND 20732 permit. Pages 1 and 2. Department of Health a Important; If item 27 Is any Injury or other trauonce. PHYLLIS CHESLEY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST. CHARLES CEMETERY SEPT. 18,2007 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Stall re of Funeral Service Ucenster

LYDIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, HOME, P. A. ROAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cong disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of): Examine be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō Month Day Year in the past 12 months? 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1□ Yes 2□No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2 **□** No 1 🗌 Yes 1 🔲 Inpatient Certification: To this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident al or Attences after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Box 68760, Division or Vital Records, within 24 hours at To the Funeral D Hospital

Baltimore, Maryland 21215-0036

Registrar

State

Kamakshi Baig 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

SEP 1 4

6620 Crain Highway Suite 102 La Plata, MD 20646 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-0056949

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LEWIS EDWARD DIMLER 5 SEP 2007 6:03 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Months Yrs. Director 202-32-3413 SEP 20, 1941 65 <u>Pennsylvania</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show notified at 1 ☐ Yes 2 X No Director VA Fairfax Annandale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be 4824 Ponderosa Drive 22003 United States Funeral Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1959 - Year or Dates: 1979 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) 4 Intelligence Analyst Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۴ <u> Clair Jacob Dimler</u> Edna Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope N. Dimler/Wife 4824 Ponderosa Dr., Annandale, VA 22003 20b. Place of Disposition (Name of cometery, crematory or other plane Fairiax Memorial Funeral Home 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2007 Fairfax, VA 22. Name and Address of Facility
Fairfax Memorial F
9902 Braddock Rd., 21. Signature of Funeral Service Licensee Funeral Ho Fairfax, M01508 22032 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2X No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a Was an autopsy perform 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death 2 Accident hours after death uneral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and Ne of certifier 29d. Date pigned (Month, Day, Year) D-65886

State Registrar

GEOFFREY KIM 31. Date filed (Month, Day, Year)

SEP 1 3 2007

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

mark!

200

CENTER

06

20889-5600

NATIONAL NAVAL MEDICAL

BETHESDA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Denise Darlene Dorsey Deatember 07 2007 /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Virginia 6. Sex Age (In vrs. last birthday) Under 24 Hrs 8. Date of Birth (Month, Day, Year **Funeral** 1 □ M 2 □ F Yrs 48 Director 223-98-9998 1959 16, May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1822 Monroe Street USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyghene. Important: If item 27 Is marked other than "natural", or items 23s any injuy or other traumatic event, the Medical Examiner musts Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No **Black** Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Disabled 12th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tommy Lee Dorsey, Sr. Rebecca Spratley Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1822 Monroe St. Baltimore, Md. 21217 Felecia Dorsey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sept. 15,'07_{Spring} Grove, Virginia any injury o Davis Cemetery 4 Donation 5 Dother (Specify) 8721 Colonial Trail E. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smithfield, Virginia23430 Poole's Funeral Home MD 278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to min solute cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 🔀 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEP 1 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Amended Item 20a per F.D. 09/14/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09 2007 08 4 pm Natalie Dickerson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** College View Nsg. Ctr. 700 Tollhouse Ave. Fred. MD Frederick 8. Date of Birth (Month, Day,)
Dec 23, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X X 227-14-7319 1921 **Director** VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Howard Woodbine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21797 2120 Duvall Rd United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Homemaker</u> her home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Busby Earle R Hawkins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16020 Buggy Whip Dr.

FIbert Colorado 80106

20b. Place of Disposition (Name of cemetery, crematory or other place) Emily Solomon (daughter) 20c. Location - City or Town, State 20a. Method of Disposition riat 2X Cremation 3 Removal from State Carroll Crematory 9/12/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one cause on each line. Winfield, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementia years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) signed by the attending physician I be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐XNo Certification: To after death.

I Director: After this d in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

WIL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

65-L Thomas Johnson Dr.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shah

Steers Signature

D60417

Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Sept 9:30 pm Arthur H. Dorsey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** North Hampton Manor Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days **1** 2 □ F 77 216-30-2974 Director 21. 1929 MD Dec Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2XNo Director MD Mt. Airy Carroll 10e. Street and Number 10g. Citizen of What Country? 1340 Davis Rd 21771 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIo Specify: Black ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Refuse Worker United Disposal Co 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 Is marked o Pages 1 and 2 should be Basil K. Dorsey Mandella Costley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1491 W. Charles Dorsey (brother) 9th St. Frederick, MD 21702 If item or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1XXurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet Cem 9/19/2007 Owings Mills, MD 21. Signature of Funeral Service Licen-22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, flany, leading to inneclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a sthe burial-P.O. Box 68760 Physician/Medical as IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 TYes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🛇 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 WJZ 5+1VA Tou House Ave, Frederick 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caridi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2007

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of Ma	aryland	-	artment of F ertificate of			ntal Hyg B	giene Reg. N	007	31140	
Î	Physicia	an	1. Decedent's Name								Date of Dea Month	ith Day	Year	3. Time of Death /2/0 M	
	/Medic	al	Leo Harve		pach give street and number)			4b. City, Town, o	or Location		eptembe	w.9	2007 County of Death		_
Į	Examin	eı	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMIN												
	Funeral Director		5. Social Security N 207-34-0	549	Sex 7. Age	e (In yrs. la 64	st birthday Yrs.	Months Days	If Und Hour	der 24 Hrs. 8. 's Min. Ja	Date of Birth (Month, Day an. 21	Year)	Cou	place (State or Foreigr intry) sylvania	1
	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits	
	e Mar sa-f sh tiffed	Director	PA	Montgon	nery	Pot	tstow	n						1X Yes 2 No	
BAITIMORE, IMBRYIAND ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	308 High					10f. Zip Code 19464				10g. Citiz USA	zen of What Cou	intry?		
	by Funeral	11. Marital Status	ied 2K Marrie	12. Was Decedent I Armed Forces?		If Yes, specify Cuban, Mexican							ican Indian, , etc. ite		
2-003p	72 hou natura dical E		(Spec	15. Decedent's	Education grade completed)		(Giv	edent's Usual Occup e kind of work done	during n	nost of working		16b. Kir	nd of Business/l	ndustry	
7	within ene.	Completed	Elementary/Seco		College (1-4or 5	5+)	`life.	DO NOT use retire	ed)	_		Law	Practi	ce	
20	e filed Il Hygia other vent, t	Be Co	17. Father's Name	(First, Middle, La					18. Mc	other's Name (F	First, Middle,				_
yland	Menta Menta arked atlc ev	ToB	Harvey Es							ricia O					
Mar	12 sho		19a. Informant's Na Jean E. H					iling Address (Street						ip Code)	
<u>၈</u>	tem 2		20a. Method of Disp		<u> </u>	20b. Pla	ace of Dis	Highland position (Name of rematory or other pla		POLLSTO			464 cation - City or T	Town, State	_
Ē	Pages nent of int: If i			©Cremation 3 5 ☐ Other (Spe	Removal from State	- I .	erty	Crematory		Sept 10		Ph:	iladelpl	nia, PA	
pairimo	permit. Departr Importa any inju	5	21. Signature of	n Service	cense m	01170	S	22.Name and Addr picer-Mul ew Castle	ess of Fa liki DF	n FH 10	000 N I	DuPo	nt Pky		
	Physician	4	Z3a. Part1. Enter t shock, or hea Immediate Cause (disease or condition	art failure. List o (Final	omplications that caused hly one cause on each lii	the death	. Do not e	the mode of dy	ing, such	as cardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	-	Due to (or as	-									
Ľ.	i Sel	ē	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, nmediate	b. — Due to (or as	a consequ	ence of):								-
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58/pn,	ficate be executed physician and is the burial-transit	edical Ex	resulting in death) l	Last	Due to (or as	a consequ	ence of):								s))
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O. Box	eath atter for u	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	! months? ☐ No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	B Ectopic pregnand Dother (specify)	ру			2	23d. Date of deli Month	very Day Year	
ecords, P	w requires that the de been signed by the should be detached	b	Part II. Other signi	ficant condition	s contributing to death b	ut not resu	Iting in the	underlying cause gi	ven in Pa	art I.	23e. Did to			the cause of death?	n
r	has has	Completed											prior to death?	topsy findings available completion of cause of 2 □ No	е
Z Z	Physician: The this certificate ral director, pag	Be C	25. Was case referexaminer?		Hospital			101	hor	lace of Death (_
0	Phys this ral dii	- To	1 ☐ Yes 2 ☐		28a. Date of Inju		ER/Outpati 28b. Time	ent 3 DOA			e 5 🗆 Resid d. Describe l		6 ☐Other (Spectry occurred	cify)	_
UNISION	al or Attending Ph s after death. it Director: After thi d in by the funeral i	Certification:	1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 ☐ Pending investiga 6 ☐ Could no determin	t be 28a Place of ini	ury - At ho			Yes 2		f. Location (S City or Tox	Street an vn, State	nd Number or Ru	ral Route Number,	
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one)		Physician: To the best xaminer: On the basis of and manner st	of examinat									
	To th within To th comp	Me	29b. Signature and	title of certifier				29c. Licen				29d. Dat	te signed (Monti	h, Day, Year)	
			1 0	K W					226	197		91	8/07		
	10		0	ress of person w	ho completed cause of a	st. S	23a) (Typ	e, Print)	2180) (
	Sta		31. Date filed (Mor	nth, Day, Year)	0 E_ Carro 11 32. Registr 2 2007	rar's Signat	ture	Apolle 1							
	Regist	rar		ULP 1	2007	we	s ,	The same of the sa							

DHMH 17 Rev 1/2001

Leo Eschbach 910-31-7209

Certificate of Death

2. Date of Death 1. Decedent's Name (First, Middle, Last) 6 Day 200 Year SEMPT. **Physician** RUI RONG FAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ROCKVIII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day,
Tuly 8 Rockville Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 80 219-23-5284 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jury or other traumatic event, the Medical Examiner must be notified at once. Gaithersburg Director MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20886 51 Crested Iris Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes **Ş☐X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Carriage Hill Elementary/Secondary (0-12) College (1-4or 5+) Nursing Care Worker Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 118 Lake Street, Gaithersburg, MD 20878 Jimmy Yan (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify) 9/15/07 Rockville, MD Park*h*awn Mem Park 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service License 246 N. Washington St, Rockville, MD 20850 ese se, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final Physician Gastrointestinal Bleeding disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Pneumonia resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical <u>Diabetes Mellitus</u> IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Advance Alzheimer's Dementia 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) M.D D0056428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9/10/07 19519 Doctors Drive, Germantown, MD 20874

Month

1752

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Vear

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐Yes 2 ☐ No

MONTGOMERY

China

U.S.A.

14. Race - American Indian.

Black, White, etc.

Specify: Asian

DHMH 17 Rev 1/2001

State Registrar Humerva Malik,

M.D.

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 7, 2007 Month **Physician** Doris C. Fleishman September 7:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolitan Assisted Living Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 92 212-28-3569 Director 16, 1915 Jan. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Director MD Anne Arundel Arnold 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Brent Road 21012 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature" any injury or other traumatic across once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hair Stylist/Owner/Operator Beauty Salon 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Mitchell Catharine Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frank J. Fleishman/Husband 121 Brent Road Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Septate 10, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park 2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Since of F 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. haral Sen Severna Park Funeral Home Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Mitmi Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has bage 2 s 1☐ Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 COther (Specify this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending Injury 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 28686 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

SEP 1 2 2007

ORIGINAL

			For State Registrar	State of N	Marylan		artment rtificate			d Mental I	Hygier Reg. 1	ne No.20	07	311	43
	Physici	an	Decedent's Name (First, Middle John Alfred Fre							2. Date of Month	Death	Day	Year 2007	3. Time of De 3:30	
*	/Medic		4a. Facility Name (If not institution		<i>θr</i>)		4b. City,	Town, or	Location of De			4c. County		3.30	a
Å	Exami	iei	FutureCare Che					Ar	nold			An	ne Ar	rundel	
	Funeral Director		5. Social Security Number 215–74–3252	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. 8. Date of Month	Birth Day, Ye,	1965	Coun	lace (State or F try) ryland	-oreign
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	eation						1	0d. Inside City I	Limits
	Maryla -f shov iled at	tor		hester	100. 011		bridg	е						1 □ Yes 2	
	with the a or 28a be notif	Director	10e. Street and Number 5818 Hudson	Wharf Road			10f. Zip Code 21613						What Coun	try?	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.	Funeral	11. Marital Status 1 □ Never Married 2⊠ Marr	12. Was Decede Armed Force	es?		Was Deced If Yes, spec	lent of Hi cify Cuba		(Specify Yes o lerto Rican, etc.	r No-	Blac	e - Americ ck, White,	etc.	
Maryland 21215-0036	72 hours natural", lical Exal	Completed by	3 Widowed 4 Divorced 15. Deceden (Specify only higher	Year or Date t's Education	es:	16a. Dece	dent's Usua kind of wor	al Occupa	ation during most of v	working	16b	Specify: White 16b. Kind of Business/Industry			
2121	d within giene. er than " the Med	omple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	Labo	se retired				Construction			
land	ild be file lental Hy ked othe ic event	To Be (17. Father's Name (First, Middle, Last) 18. Mount S Name (First, Middle, Last) 19. Mount S Name (First, Middle, Last) 19. Mount S Name (First, Middle, Last)												
Mary	nd 2 shou Ith and M 27 is mai	-	19a. Informant's Name/Relations Tracie L. Fros				ng Address 9 Tho			Rural Route No Glen		ty or Town, nie, M			
ore,	tges 1 and to 1 to 1 Heal		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		ate c	Place of Disponentery, creation (matory or o	ther plac		pt. 11, 2007	200	. Location -	City or To		
Baltimore,	ermit. Pa epartmer nportant ny injury		4 □ Donation 5 □ Other (S 21. Si_nature / Funeral Service		100	25	2 Name an	d Addres	ss of Facility & Sons, Ritchie		 Seve:			•	Home
	20 E # 9		290 Parts Pater the disease or	complications that cause	sed the deat								ark,	MD 2114 Approximate	16
354	Physician	9	23a. Part1. Anter the disease, or shock, or heart failure. List Immediate Jause (Final disease o ondition resulti in death)		ic Bra				3 ,		,,			Interval Betwe Onset and De	en ath
	/Medical Examiner	(as a consequence vehicle		ciden			er 2005		2			
	uted d ansit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due to (or	as a consequ	uence of).		CERTIF	CATION APPRO	VED BY MEDICA	XXAHIM	ERV)		
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Exa	resulting in death) Last		as a consequ	uence of):		(104				*		
9	eath certificat attending phy for use as the	/Medi	IF FEMALE:	23c. If yes, outco	me pf pregna	ancy						23d Da	ate of delive	erv	
.O. Box		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 □ Feta nt at time of d n		⊒Ectopic pr ⊒ Other <i>(sp</i>				_		onth		ar
rds, P	w requires that the s been signed by th should be detache	by	Part II. Other significant condition	ons contributing to deat	th but not res	ulting in the u	inderlying c	ause give	en in Part I.		Did tobac 1 □ Yes	co use con 2 ∑ No	tribute to tl 3 Prob	he cause of dea cably 4 ∐Un	Year of death? Unknown Ings available of cause of Number, ter, MD
or Vital Records,	e law has b je 2 st	Completed									Was an autopsy performed es 2 X		prior to co death?	ppsy findings av mpletion of cau 2 No	railable use of
ital	sician: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?							Death (Check o					
<u></u>	ys dir	မ	1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp	patient 2	ER/Outpatie			4A Nursin	g Home 5		e 6 □Otl		y)	
on	Attending r death. ector: After by the funer	tion	1 □ Natural 5 □ Pendir 2 🔀 Accident investi	ng (Month,	Day Year)	Unkno		28c. Injur Worl 1 ☐	k? Yes 2.231No	1		volve		MVA	
Division	or Atter ifter dea Director in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 290 Place of	f injury - At ho g, etc. (Specif	ome, farm, st fy)	reet, factor	y, office		28f. Locati City o	on <i>(Str</i> ee r Town, S	t and Numi state)		al Route Numbe	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce		ng Physician: To the base and manne	est of my kno								anner as s	stated.	,
	To the within 2 To the comple	Mec	29b. Signature and title of certifie		1	10.1		7	e number		0	1 _ /	1_	Day, Year)	フ
•	IN.	10	30. Name and address ownerson	will completed cause	of death (Item	n 23a) (Type	Print)	1)	5070		/	,	1	13.5	
	Str	ate	31. Date filed (Month, Day, Year,		gistrar's Signa	60/ V	eter	ans	Hwy	Mil	gri	s vo C	le p	11) 21	108
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		1 - State Registrar		Maryland / [Certifica	te of i	Death	ania iv		Reg. No		7	311	44
Physic /Medi		1. Decedent's Name (First, Middle, L Ursuline Elizabet	h Gannett						2. Date of De. Month Septemb	er 11	ĭ, 200Ť	′ear 7	3. Time of 5:30	
Exami	ner	4a. Facility Name (If not institution, gi Bradford Oaks Nursi	ng Home		(linta				Pr	County of		es'	
Funeral Director			Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last birt	Month	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 07/01/1	h y, Yea <i>r)</i> 9 20	5	Coun	lace (State of htry) Caroli	
works 1-4 show	tor	10a. State 10b. County	PG	10c. City, Town								1	0d. Inside Ci	•
natural', or items 23a or 28a-f show digal Examiner must be notified at	I Direc	10e. Street and Number 7520 Sunratts Road			10f. Z	ip Code 20735					tizen of Wh	at Coun	ntry?	
nal Hygiene. sd other then "natural", or items 23a or 28a-f show avent, The Medical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ➡ Divorced	Armed Force 1 Tes 2 If Yes, Give	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: ducation ade completed) College (1-4or 5+) Ordair			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☑ No Specify:				ifly Yes or No- ican, etc.) 14. Race - Ar Black, WI			
al Hygiene. I other then "natu vent, I've Medical	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12th	rade completed) College (1-4c				during most)	of worki	ng		b. Kind of Business/Industry Private			
and Mental Hy is marked oth raumatic aven	To Be	17. Father's Name (First, Middle, Las George A. Kairson	t)						(First, Middle, Williams		Sumame)			
of Health and Ment I item 27 is marked r other traumatic a		19a. Informant's Name/Relationship Ursuline Kairson – Da			-				e; Paris	or, City o		ate, Zip	Code)	
nent of Hea int: If item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific Control of Con		20b. Place of cemeter)		ame of other plac	θ)		ate	20c. Lo	bver, 1	•		
Department of H Important: If ite any injury or ot once.		21. Signature of Pineral Service Lice	Hulla	DE	22. Name	and Addres	s of Facility	Free	man Funer Hills, Ma	al S	ervice	s		
Medical Medical sthe private state of the private s	dical Examlner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (1998), that initiated events resulting in death) Last	Due to (or a	er's Diseas as a consequence of as a consequence of as a consequence of	f): f):								***************************************	
ned by the attending ph detached for use as th	Physician/Medi									23d. Date of delivery Month Day Yea			/ear	
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this certificate al director, pag	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation	28a. Date of In (Month, L	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Hore Oth						eath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
tin. ; After this e funeral	(0	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							8f. Location (S City or Tow	treet an n, State	d Number (or Rural	Route Numi	ber,
tor:	Sertific	4 Homicide												
within 24 hours after death. To the Funerel Diractor; After completely filled in by the funer	edical Certification:	29a. Certifier 1. Certifying Pl	hysician: To the bes miner: On the basis and manner:	of examination and	death occurre for investigation	d at the tim	e, date and inion, death	place, a	and due to the o	ause(s) date and	and manne place, and	er as sta due to	ated. the cause(s)	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 8:20 aM Evelyn Delores Gottlieb 2007 September /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 209-18-7895 81 February 2.0, 1926 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20905 U.S.A. 14820 Fireside Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Catherine Tyne Evermond Augustus Holford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley H. Gottlieb - Husband 14820 Fireside Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2007 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Seprice License Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complical or that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one as se on each line. Approximate Interval Between Onset and Death PNELMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): OBSTRUCTIVE PULMENARY DESEASE 20 YEARS Examiner (HRONZI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Detal death 1☐I ive hirth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò KYPHOSCOL ZOSES 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 7, 2007 struck of mayor, 023630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANK J. MAYO, MO 16220 FREDERICK RD # 213 GAITHERSBURG, MARYLAND 20877

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

			1 - For State Registrar	State of	f Marylar	_		nt of H		nd Me	ental Hy	giene Reg. No. (200	7	3114	6
	Physic	an	1. Decedent's Name (First, Middle,								2. Date of Do	eath Day	Yea	3.	Time of Death	_
	/Medi Examir	cal	Ginette Theres 4a. Facility Name (If not institution, g				4b. Cit	y, Town, or	Location of I		Septem	1	L1, 20 County of De		7:27 a M	_
	Funeral		Montgomery Gen 5. Social Security Number 6		oital 7. Age (In yrs.		If Und	Oln er1 Year	If Under 24	4 Hrs.	8. Date of Bi	rth a <i>y, Year)</i>	9. B		mery (State or Foreig	n
	Director		220-94-4647 Usual Residence of Decedent 10a. State 10b. County	ILIM Z W IF	44	Yrs.	1					, 196	1	shin	gton, Do	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show propriant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any joury or other traumatic event, the Me Ical Examiner must be notified at once.	by Funeral Director	Maryland Mont 10e. Street and Number 18036 Wagonwh 11. Marital Status 1 □ Never Married 2 Married	12. Was Dece	edent Ever in U	I.S. 13.	Was Dec	ip Code 20 sedent of Historical Cubar	n, Mexican, I	n? (Spec Puerto F	eify Yes or N lican, etc.)		en of What (U 4. Race - An Black, Wh	Country?		
121215-0036	2 should be filed within 72 hours at and Mental Hyglene. Is marked other than "natural", or aumatic event, the Medical Exam	Completed	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Le	If Yes, Gin Year or D. Education grade completed) College (1	ve ates:	16a. Dece	dent's Us kind of v DO NOT	use retired)	uring most o	ry	g (First, Middle	16b. Kin	od of Busines	s/Indust		
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Maryland	1 and 2 short Health and N em 27 Is ma other trauma		19a. Informant's Name/Relationship Sylvester Gilbe	rt/Husba	nd	19b. Maili	ng Addre						Town, State Olney		^{de)} 20832	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo cemetery, cre te of	matory o	r other place	' !	-	nte 15, 007		eation - City o		State Maryla	nć
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lie	Colly	ass								ne Inc		MD 2090	01
8760,	Physician // // // // // // // // // // // // //	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. He Due to (or as a consector as	duence of).	e ha	Cana	ny cer					<u>I</u>	erval Between set and Death	
P.O. Box 6	requires that the death certificens is greed by the attending prould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come pf pregn pirth 2 Feta ant at time of cown	al death 3[⊒Ectopic ⊒ Other	pregnancy (specify)				2	3d. Date of o	delivery Day	y Year	
Records,	aw requi	Completed by PI	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	underlying	cause give	en in Part I.		1 24a. Wa	Yes 2	No 3□	Probably autopsy o comple ?	ause of death? y 4 □Unknowi findings availabletion of cause of] No	
Vit	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 10	npatient 2] ER/Outpatie	nt 3□	OCA Othe	r'		(Check only		□Other (Si	necify)		
Division or Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ation: To	27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		28b. Time o Injury		28c. Injury Work		2	8d. Describe			scony		_
Divis	Ital or Att rs after de ral Directa led in by t	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 26e. Place buildi	of injury - At h ng, etc. (Speci	ify)				J. Vi	City or To	own, State)			oute Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in it	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the caminer: On the b and man	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	th occurr nvestigat	ed at the tim on, in my o	ne, date and pinion, death	l place, a h occurre	nd due to the d at the time	e cause(s) : e, date and	and manner place, and c	as state lue to the	d. e cause(s)	
	To the complete compl	Me	29b. Signature and title of certifier	2	_		2	9c. License	number	7661		29d. Date	e signed (Mo	onth, Day	, Year)	
	~		30. Name and address of person w		se of death (Iter	m 23a) (Type	Print)	Philip	Drive	2. 0	neu.	MD 2	20332			_
	St. Regist		31. Date filed (Month, Day, Year)	20. 5	strar's Sign	ahura				1) / `		Quant			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donna Maria Heiss Sept 12, 2007 6:22 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 220-34-0053 71 May 7, 1936 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Prince George's Riverdale 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 Patterson Street 20737 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Accounts Payer County Library System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Aubrey Custer Maude Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Trupe - Daughter 7111 Decatur St., Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Cemetery 9/17/07 4 □ Donation 5 □ Other (Specify) Petersville, Maryland 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signatu Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nounem Sequentially list conditions, if any, leading to initiodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to I Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform

Physician /Medical Examiner

injury or other

Funeral

Director

a or 28a-f show be notified at

"natural", or items 23a

Health and Mental Hygiene. em 27 is marked other than

Pages 1 and 2 should

Completed by Be Certification: To

25. Was case referred to medical examiner? 27. Manner of Death

attending physician and for use as the burial-tran

been signed by the should be detached certificate this

Box 68760,

P.O.

Division or Vital Records,

To the Hospital o within 24 hours af To the Funeral D

To the Funeral Director: After th completely filled in by the funeral 0

30. Name

1 ☐ Yes

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

Medical

4 Homicide

2 No

title of certifier

State Registrar

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined

1 Inpatient

and manner stated.

Hospital:

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of Injury at Work? 1 ☐ Yes 2 ☐ No

2 ☐ ER/Outpatient 3 ☐ DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

D53111

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

28d. Describe how injury occurred

who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pk. Annap Tran Davis

32. Registrar's Signat

DHMH 17 Rev 1/2001

Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

with the Maryland

Baltimore, Maryland 21215-0036

nours after death.

neral Director: After this

filled in by the funeral di within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Cames CLOPMCIK 31. Date filed (Month, Day, 32. Registrar's Signature State 18 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

			For State	State	of Maryl		artment of I rtificate of		d Mental Hy		O =71	211	EO
亦	6 m the	100	Registrar 1. Decedent's Name (First, Mid	Idle. Last)		- 00	Tillicate of	Dealli	2. Date of D	Reg. No.	U I	3. Time of	Dooth Dooth
	Physic		Coyal Rol		n				Month Septembe	Day	Year 2007	6:05	
	/Medi Exami		4a. Facility Name (If not institut				4b. City, Town,	or Location of De		4c. County			
			Shady Grove N	ursing Home	е			Rockville		Мо	ntgome	ery	
	Funeral		5. Social Security Number	6. Sex 1⊠ M 2□		rs. last birthday)	If Under 1 Year Months Days		Irs. 8. Date of Bi in. (Month, D	rth av. Year)	9. Birth	place (State or	r Foreign
	Director		215-32-3851	I KA IVI Z	6	9 Yrs.		7100.0		r 12,1937		yland	
	land ow t		Usual Residence of Decedent 10a. State 10b. Cour	ty	10c.	City, Town or Lo	ocation					10d, Inside Cit	v Limits
	Mary -f sh	ţō	Maryland Mor	tgomery			Laytonsv	ille				1 ☐ Yes	
	h the r 28a	Director	10e. Street and Number				10f. Zip Code		100	10g. Citizen of	What Cou	ntry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		6514 Garden	Grove Way				20882			U.S.A	Α.	
	r dea	Funeral	11. Marital Status	12. Was I	Decedent Ever in d Forces?	n U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	o- 14. Rac	ce - Americ	can Indian,	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ M	arried 1 X Y	es 2∏No , Give or Dates.1958•		1 ☐ Yes 2 ₺ No		51.5 1 1154.11, 51.51)	Specif	h.c.		
8	hour tural	o pa	3 ☐ Widowed 4 ☐ Divorce	ent's Education	or Dates:4330		dent's Usual Occu	nation				B1ack	
15	in 72 n "na Aedic	Completed	(Specify only high	nest grade complet		(Give	kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of B	usiness/In	dustry	
212	filed withir Hygiene. other than sent, the Me	E	Elementary/Secondary (0-12	Colleg	ge (1-4or 5+) 5+	So	cial Worke	r		D.C.	Govern	nment	
Maryland 21215-0036	be filed within 72 hortal Hygiene, dother than "natu event, the Medical	Be	17. Father's Name (First, Middle	e, Last)				18. Mother's N	lame (First, Middle	, Maiden Surnan	ne)		
yla	Ment Ment arkec	흔	Bartimus Jays	on				Rub	y Jeffersor	ı			
lar	2 sho and is m		19a. Informant's Name/Relatio						Rural Route Numb				
e,	1 and Health		Ramona C. Jayso 20a Method of Disposition	n - Spouse	201			ve Way, L	aytonsville				
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it once.		1 X Burial 2 ☐ Cremation		om State	-	natory or other pla	i	Date	20c. Location -			
Ħ	artme prrant		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Serving		Ma Ma		terans Cem		/14/2007	Crownsvi	11e, M	laryland	
Ba	permit. Departr Importa any inji		* Tours	N Len	Drum	Hi	nes-Rinald	i Funeral	Home, Inc. venue, Silv	er Spring	Mars	12nd 200	90% -
			23a. Part1. Er er the disease,	or complications th	at caused the de						, mary	Approximate	
	Physician		shock, of heart failure. Li Imme the Cause (Final disease or condition	storily one cause (v 1.		· · · · · · · · · · · · · · · · · · ·	=		Interval Betw Onset and D	een eath
	/Medical		resulting in death)	a. Due	to (or as a cons	equence of):	1 1	SCEL	21 431.	32431C			
В	Examiner		Sequentially list conditions,	b		57576	2						
	ed sit	ine	if any backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dine	to (or as a cons	equenno of)							
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c	to (or as a cons	equence of):							
68760,	icate be executed physician and s the burial-transit	dical			((- 1							
.89	ifficate g phy as the	- W T									_		
Вох	death certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf preg		·			23d. Dat	te of delive	ery	
	ed for us	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	ve birth 2 □ Fo egnant at time o nknown		Ectopic pregnancy Other (specify) _	<u> </u>		Mo	onth	Day Ye	ear
P.0	w requires that the dispension signed by the should be detached	Phys	9 Unknown										
	ires the signed be do	þ	Part II. Other significant condi	tions contributing to	o death but not r	esulting in the ur	iderlying cause giv	en in Part I.		obacco use cont			- 1
Records,	requires been sign hould be	Completed				·			_ 1 _ 1 _ 1	Yes 2 (No	3∐ Prob	ably 4 ∏Ur	iknown
Rec	The law ate has b	d m							24a. Was autoj	osv i	Were auto prior to co	psy findings a mpletion of car	vailable use of
	n: Th ficate or, pag		25. Was case referred to medic						1 Yes	ormed?	deatn? 1 ☐ Yes	2/2No	
or Vital	Physician: this certificaral director, I	o Be	examiner?	Hoenital:	☐ Inpatient 2	□ EP/Outpation	t 3□ DOA Oth	or:	eath (Check only c				
10	g Phy er thi	입	27. Manner of Death	28a. Da	ate of Injury	28b. Time of	28c. Injur	4 yursing	Home 5 Resident	dence 6 LOther		y)	
Division	Attending I r death. ector: After by the funer	Certification:	1 Natural 5 Pend 2 Accident inves	ng (N tigation	fonth, Day Year)	Injury		k? Yes 2 ∐ No					
ivis	er de recto	ţį.	3 Suicide 6 Could 4 Homicide deter	mined 280. Pla	ace of injury - At illding, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rura	l Route Numb	er,
D	nital or A urs after ral Dire lled in by								NA .	,			
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) Certify 2 Medica	ing Physician: To I Examiner: On the	e basis of exami	nowledge, death nation and/or inv	occurred at the tire estigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time.	cause(s) and ma	inner as st	ated. the cause(s)	
	o the omple	Med	29b. Signature and title of certific	and m	anner stated.	٨	29c, Licens						
	12					()				29d. Date signed			
	12	-	30. Name and address of perso	who completed a	ause of death /It-	em 28a) (Type I	Print)			9-0			
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	Sta	е	 Date filed (Month, Day, Year 	2007 32	. Figistrar's Sig	nature	2		11/06 11 6		-AIRKG		CC37
	Registra	ar	SEP 1	3 2007	Streve	J. A.	well)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Joseph Key, Jr. 10:10 PM September 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₩ 2 □ F 578-58-3217 62 January 1, Director 1945 Edgefield, SC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 7106 E. Clinton Street 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years U.S. Postal Service Employee Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Key, Sr. Essie Dell Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor M. Key - Wife 7106 E. Clinton Street Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Sept. 18, 2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service License 4001 Benning Road, NE Washington, DC 20019 23a. Parl 1. Sinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show on eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending should be detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bowel Obstruction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Small 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 s autopsy performed? Yes 2/1/No this certificate the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig D006480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID latel 7501 Surrats Rd Clinton, MD 20735 32. Registrar's Signat 31. Date filed (Month, Day, Year) State SEP 1 4 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Physician Month SEPT. 12° 2007 CARL ERNEST KING 12:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Days 207-28-4390 70 Director Pennsylvania March 28 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Montgomery Derwood 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Horizon Court 20855 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1956 If Yes, Give 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. White Specify. þ 3 ☐ Widowed 4 ☐ Divorced 1977 Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Control Technician U. S. Navy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry King Alice Helen Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanna King / Wife 1 Horizon Court, Derwood, - bM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/13/07 Alexandria, Va. Metropolitan Crem. 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 1-00470 P. O. Box 5038, Laytonsville, Md. 20882 23a. lart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** 3 Days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, bisease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1⊟ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 € Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. ⚠ Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 12, 2007 D 64502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 9901 Medical Center Drive, Rockville, Md. Brian Carpenter, M.D. 31. Date filed (Month, D egistrar's Signatur State 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month ¿Physician Year BARBARA E. LOWE 09 07 2007 21:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Days Hours 170-34-7956 Yrs. Director 66 05/28/1941 CANONSBURG, PA Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7403 MARY SCOTT DRIVE 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2 YEARS REGISTERED NURSE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH C. LOWE SARAH E. PENN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6651 ROCKLEIGH WAY ALEXANDRIA, VA 22315 JANETTE STEWART-CURETON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 09/14/2007 RIVERDALE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility $J.B.\ JENKINS\ FUNERAL\ HOME$ 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BI-VENTRICULAR Due to (or as a consequence of): ACUTE M Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Exami Alheroscherolic Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide

/Medical Examiner physician and s the burial-transit that the death certificate be executed Records, P.O. Box 68760 attending pl been Jas Division or Vital

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

traumatic event, the

03

Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other trai

permit. Page Department of Important: If any Injury or

should be filed within 72 hours after death on the Mental Hygiene. In marked other than "natural", or items 23s

12 should be f h and Mental H

Baltimore, Maryland 21215-0036

page 2 should certificate l this After t death. ģ

Hospital or Attending within 24 hours after death To the Funeral Director:

State Registrar

filled in

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53733

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

09/12/2007

wno completed cause of death (item 23a) (Type, Print) 30. Name and address of pers

HOSPITAL DRIVE SUITE H405 CHEVERLY, MD 20785 3001 SANJIV LAKHANPAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year,

29b. Signature and little of certifier

4 Homicide

(Check only one)

SEP 1 4 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Gordon Arthur Lynn	1- For State	tate of Maryla	•	ment of ficate of		Mental	Hygiene	Reg. 1	2	007	3115
Physician/		dle,Last)					2. Date	of Death			ime of Death
Medical Examiner	001 4011 111 011				011 7	lin	Septe	ember 1	0, 2007		1810 hrs
•	4a. Facility Name (if not instituti Washington County I	-	mber)	4	b. City, Town, or L Hagerstown	ocation of D	eath		4c. County of Washingt		
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 2	4Hrs. 8. Date	e of Birth (N	/M/DD/YYYY)	9. Birthpla	ce (State or
Director	217-76-8620	1 X M 2 F	49	Yrs.	Months Days	Hours	Min. Jur.	ne 16	1958	Country	California
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vith the Maryland 23a or 28a-f show a snotified at once al Director	13316 Fairf	ax Road		_	101. Z.p 0000	21742)			S.A.	
with the s 23a e noti	11. Marital Status	12. Was Dec	edent Ever in U.S.		Decedent of Hisp	anic Origin?	(Specify Yes		14. Race -	American	Indian, Black,
r death with or items 23 must be no	1 Never Married 2 X	Married Armed Fo		lf Y€	es, specify Cuban,	Mexican, Pu	uerto Rican, e	tc.)	White,		
s'after rall', o		ivorced If Yes, Give Yea or Dates:			Yes 2 X No			: 140	Specify:	Whi	
"natu	15. Decedent's Education (Sp Elementary/Secondary (0-12			during mo	's Usual Occupationst of working life.			16	b. Kind of Bus		
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215-0036 be filed within 7 ral Hygiene. rked other than ent, the Medica Be Comple	17. Patrier's Name (Pirst, Middle	e, Last)			1	8.Mother's N	Name (First, M	liddle, Maid	den Surname)		
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MD 21 nd 2 should 1 lith and Mer m 27 is mar aumatic ev	19a. Informant's Name/Relation Diana Marie		wife		Address (Street Fairfax				•		
and 2 and 2 fealth item 2 traum	20a. Method of Disposition	. Lylli	20b. Pia	ce of Disposi	tion (Name of cem		Date		Oc. Location -		
nore ages late of H		on 3 Removal fr		matory or oth t Have:	erplace) n Cemetei	ry	9-17-2	2007 F	Hagerst	own.	Maryland
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	4 Donation 5 Other 21 Supplies of Funeral Service										
E P P E	1) under	A. II	in		ame and Address 31 Easte						
Physician / /Medical	23a. Part I. Enter the disease, of failure. List only one cause	se on each line.	/		e mode of dying, s	such as card	liac or respira	tory arrest,	shock, or hea	rt A	pproximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)		Thromboemb	olism			-				Death
	Sequentially list conditions,	b.	consequence or).								
ner	if any, leading to immediate cause. Enter Underlying Caus		consequence of):								
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last	C.	consequence of):			-					
and tra		d			·	_					
D, be exe sician ourial -	UNPENDED	AMENDED									
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate b hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physinapletely filled in by the funeral director, page 2 should be detached for use as the build all the funeral director, page 2 should be detached for use as the build all certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of pregna pirth		tal death 3	Ectopic p	regnancy		23d. Date of o Month	delivery Day	Year
OX 6 ath cert attending or use a		Inknown	nant at time of deat	_ =	ner (Specify)			_ '			
b. Box the death cy the attenched for us		9 Onkii	own o death but not res	ulting in the u	nderlying cause g	iven in Part	236	e. Did toba	cco use contril	oute to the	cause of death?
P.O. es that the gened by be detacl		ntions contributing t	o death but not res	unung in the d	nachynng caaco g	ivoir iii r dic	1				y 4 🗸 Unknown
Records, The law requires firate has been signed.	-						24	a. Was an			sy findings available
e law le has te law le has te mpl							_	autopsy performe Yes 2	ed? d	eath?	pletion of cause of
al Re in: Th trifficat tor, pag e Co		cal			26.Place	of Death (C	heck only one		140	163	2
of Vital Records, ig Physician: The law requir ther this certificate has been smeral director, page 2 should 1. To Be Completee.	examiner?	Hospital: 1	Inpatient 2 🗸 E	R/Outpatient	3 DOA	Other4 N	Nursing Home	5 Re	esidence 6	Other:	
n of ving Ph. After the funeral funeral funeral	27. Manner of Death 1 V Natural 5 De		of Injury 2 n, Day,Year)	28b. Time of I		y at Work?		escribe hov	w injury occurre	ed	
Sior Attend or death. rector: by the	2 Accident Inv	ending vestigation	(1) h			es 2 N		nation (Ctr	not and Numbe	e or Bural	Route Number, City
Division o spital or Attending hours after death. meral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Co	ould not be termined (Specify)	ce of Injury - At hom	ie, iaim, stree	st, lactory, office bi	ullaing, etc.		Town, Stat		or rear	Notice Number, Only
Hospit 24 hour Funerately fill	29a Certifier	Physician: To the be		, death occur	red at the time, da	te and place	e, and due to t	he cause(s	s) and manner	as stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Ex	caminer:On the basis	of examination and								ause(s)
F 3 F 8	29b. Signature and title of certi				29c. License		OCME		29d. Date signe		
	Theodore	Mr. Kin	LIM.	uns	O.C.N	VI.E.		!	September	11, 200	/
SH 14+1	30. Name and address of person Theodore M. King, J		se of leath (Item 2 ant Medical Ex		111 Penn Str	eet. Balti	more. MD	21201			
State		- 32 P	egistrar's Signature		,		, -	-			
Registra	SEP .	7 2007	Eggs and A	7. pp	and and						

			1 = For State Registrar	State of Ma	arylan			nt of H i <i>te of L</i>		nd Me		giene Reg. No	200	77	31	155
ì			1. Decedent's Name (First, Middle, La	est)						2	. Date of De Month			Year		e of Death
	Physici /Medic		George		Levi	inson				S	eptembe			2007	2	:25 p M
	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. Cit	y, Town, or	Location of	Death		4c.	County	of Death		
_			Carriage Hill		//	to a deficiello alocal	If I los	Be er 1 Year	thesda		Data of Bird	11-	Me	ontgom		
	Funeral		5. Social Security Number 6. 5	sex 7. Ag 1⊠M 2□F		last birthday) Yrs.	Month		Hours	Min.	. Date of Bird (Month, Da	y, Year)		Coun	try)	te or Foreign
l.	Director		Usual Residence of Decedent		90		l				June 5,	191/		Ne	w Yor	К
	yland now at		10a. State 10b. County		10c. City	y, Town or Lo	cation							10	Od. Inside	e City Limits
	a-f si	ctor	Maryland Montgor	mery				Kensir	ngton						1 □ Y	′es 2k No
	or 28	Director	10e. Street and Number				10f. 2	ip Code				10g. Citiz	zen of V	Vhat Coun	try?	
	ath w		4301 Knowles A						2089	_				U.S.A		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Ded If Yes, s _l	edent of Hi ecify Cuba	ispanic Orig ın, Mexican,	in? (Specii , Puerto Ri	fy Yes or No can, etc.)	• '		e - America k, White, e		3
30	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 √ Yes 2 ☐ If Yes, Give Year or Dates:	no WWI	I	1 □ Yes	2K No	Specify:				Specify	· W	hite	
2-002p	thou atura	ed	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupa	ation			16b. Kir	nd of Bu	ısiness/Inc	dustry	
מ	hin 73	plet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or !	5+)	(Give life.	kind of v DO NOT	vork done d use retired	during most)	of working						
7	d with	Completed		4				Owner/	'CPA				Acco	unting	Firm	
2	tal Hy d oth	Be (17. Father's Name (First, Middle, Last	")					18. Mother	's Name (I	First, Middle,	Maiden	Surnam	ne)		
<u>Z</u>	ould Men arke	ျ	Bernard Levinson								Epstein					
<u>a</u>	12 sh h and 7 is m traum		19a. Informant's Name/Relationship				_				Route Numb				Code)	
ָר ע	1 and Healt em 2		Ms. Jackie S. Levi	inson - Daugn	20h P	lace of Dispo	sition (A	ame of	<u> </u>	w, was	hington			City or To	wn. State	
2	ages ent of it: if it	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		- 1	emetery, crei				9/12/2	007					
altillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any lury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		Jua	lean Mem	2. Name	and Addres	s of Facility	, ,				Maryla		
ŏ	Dep imp		Janux 1	Len	ou.	Hi	lnes-l L800 l	Rinaldi New Ham	Funer pshire	al Hom Avenu	e, Inc. e, Silv	er Sp	ring.	, Mary	land	20904
4			23a Part1. Enter the disease, or com	plications that caused	d the death											mate Between
	Physician		Immediate Cause (Final disease or condition	7.0		IEU!									Onset a	nd Death
	/Medical		resulting in death)	Due to (or as												
	Examiner	L	Sequentially list conditions,	b												
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated exerts.	Due to (or as	a consequ	uence or):										
	execur and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):										
20/00,	ficate be executed physician and is the burial-transit	Sal	•	- d												
0		ledical		- u.												
200	th cer endin r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Tectonic	pregnancy				2		te of delive	,	
	e dea he att ed fo	sici	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a 9□Unknown			Other						Мо	nth	Day	Year
٠.	law requires that the death certil as been signed by the attending 2 should be detached for use a	Phy	9 Unknown		ut not room	ulting in the cu	nd od vine	course six	on in Dort I		220 Did+	00000011	t-	ribute to th		of doath?
'n	ires the signeral land	Ď	Part II. Other significant conditions	contributing to death b	ut not resu	alung in the u	ndenynig	cause give	en in Part I.							□Unknown
colus,	w requir been si should	Completed								- 1			-		ĺ	
נו נו	The law ate has sage 2 s	Ig II									24a. Was autor		L	Were autop prior to cor death?	npletion of	igs available of cause of
ġ	n; Th ficate or, pag		25. Was case referred to medical	T							1□ Yes	2 No	1	Yes	2 Ø №	
>	rsicia s cert lirecto	o Be	examiner?	Hospital: 1 D Innatio	ent 2 🗆	ER/Outpatier	nt 3□ I	Othe	or.	-	Check only c 5 ☐ Resi		: Doth	ar (Cassib	4	
5	ding Physician: The law h. After this certificate has funeral director, page 2 s		27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		28c. Injury Work			d. Describe				7	
5	ath. pr: Aft	atio	1 Natural 5 Pending 2 Accident investigatio	n	y real)	Injury	М		Yes 2 N	10						
2	er der Irecto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined				eet, fact	ory, office		28	f. Location (S City or Tox	Street and	d Numb	er or Rura	l Route ∧	lumber,
2	ital o irs aft rat Di lled in	S														
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, t	Medical	29a. Certifier 14 Certifying Pl (Check only 2 Medical Exa	nysician: To the best miner: On the basis o and manner st	of examinat	wledge, deat tion and/or in	h occurre vestigati	ed at the tin on, in my o	ne, date and pinion, deat	d place, an th occurred	d due to the I at the time,	cause(s) date and	and ma l place,	anner as st and due to	ated. the caus	se(s)
	ithin ithin on the omple	Mec	29b. Signature and title of certifier.	and manner st	aled.		2	9c. License	e number			29d. Date	e signe	d (Month, i	Day, Yea	r)
	20			my 3	cos	mo		000	057	1124			-	11/0		
	ac		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type,	Print)									
			Truong Bao, M.D., 9	- 45			#201	Rocky	ville,	Maryla	nd 208	50				
	Sta		31. Date filed (Month, Day, Year)	2007 32. Registr	ar's Signa	ture	Acces	of s								

To the NI 0 State

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 2007

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 19, 2007

Registra

State Registrar 31. Date filed (Month, Day, Year) SEP 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMORIAL AUE, WESTMINSTER, MO 21157 ALMUTAIRY 200 MD Begistrar's Signature

DHMH 17 Rev 1/2001

D0066184

			4 101	eartment of Health and Mental Hertificate of Death	lygiene Reg. No.2 0 0 7 3 1 1 5 8
	Physici /Medi		Decedent's Name (First, Middle, Last) Ruth L. Meade	2. Date of I Month Septer	Death Day Year Mber 11, 2007 7:44 A M
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of I	
ăt.	Director	100	251-90-1645	Februa	Day, Year) ry 5, 1948 Florence, SC
	ith the Mary or 28a-f sho e notified a	Director	Maryland Prince George's Oxon Hi	.11 10f. Zip Code	1 ☑ Yes 2 ☐ No 10g. Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine: must be notified at once.	by Funeral Director	2212 Alice Avenue #102 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 □ No If Yes, Give Year or Dates:	20745 Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify:	United States 14. Race - American Indian, Black, White, etc. African Specify: American
Maryland 21215-0036	I within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) undry Presser	16b. Kind of Business/Industry Government
yland 2	rould be filed I Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) George Wheeler	18. Mother's Name <i>(First, Midd</i> Haddie Patri	ile, Maiden Surname) LCk
	es 1 and 2 short Health and Item 27 is nother traun		Reginald J. Meade - Husband 2212	ing Address (Street and Number or Rural Route Num Alice Ave #102 Oxon Hil	L1, MD 20745
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		4 Donation 5 Other (Specify) 21. Six ature of Fune Service Linese,	ematory or other place)	
8760,	Physician //Medical Examiner	ical Examiner	23a. Part). Enter the disease or complications that caused the death. Do not ensure the shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only included an account of the death. Do not ensure the disease or conditions and the death. Do not ensure the death. Do	iter the mode of dying, such as cardiac or respiratory	
.O. Box 6	eath certific attending p for use as	Physician/Med		□Ectopicpregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the user Sarcoidosis		d tobacco use contribute to the cause of death? ☐ Yes 2☐ No 3☐ Probably 4☐Unknown
	iclan: The law r certificate has be rector, page 2 sh	Completed		24a. Waul aul pei 1 Yes	topsy prior to completion of cause of death?
. Vital	ysiclan: is certifica director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check onl)	rone) sidence 6 □Other (Specify)
Division or	ing Ph	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		e how injury occurred
	oital or urs atte oral Dir Illed in	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	City or T	. (Street and Number or Rural Route Number, own, State)
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to transcription, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
	To the vithin comp	Me	29b. Signature and title of certifier	29c. License number D006/1937	29d. Date signed (Month, Day, Year)
2	_ (2)		30. Name and address of person who completed cause of death (Item 23a) (Type, CANDACE L. WILSON, MD - 1500	Print) FOREST GLEN RD; S	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4 2007 SEP 1 4 2007		

		,	1. Decedent's Name (First, Middle,	Last)					2. Date of I Month		ay \	/ear	3. Time of	Death
	Physici /Medic		Dorothy	May		McGa	th		Septem				9:26	рм
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of De	eath	4	c. County of	Death		
e S		.36	Manor Care-Silv	er Spring			Silver S	Spring			M	lont	gomery	
1	Funeral				(In yrs. last	birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of B	Birth	9	9. Birthp	place (State or	r Foreign
	Director		300-16-9733	1□M 2 x □F 8	33	Yrs.	Months Days	Hours M	July	Day, Yea 15,		Cour.	hio	
	D		Usual Residence of Decedent											
	rylar how	,	10a. State 10b. County		10c. City, To	own or Lo	cation					1	0d. Inside Cit	-
	e Ma la-f s tifiec	cto	Maryland Mo	ntgomery	S	ilve	r Spring						1 □Yes	2 K No
	th th or 28 e no	Jire	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wh	at Cour	itry?	
	23a ust b	Funeral Director	12526 Montcla	ir Drive			2090)4			USA			
	r dea	ne	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or I	No-		Americ White,	an Indian, etc.	
0	or It		1 Never Married 2 Marrie	If Yes, Give	0		I∐Yes 2√⊡No				Specify:			
Ś	ural"	d by	3√∏ Widowed 4 □ Divorced	Year or Dates:										
5	"nat	ete	15. Decedent's (Specify only highest	grade completed)		Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most of v	working	16b.	Kind of Busi	ness/Inc	Justry	
V	withir	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)		ecutive <i>P</i>			De	fense	Con	tracto	r
7	iled v Hygie ther i		17. Father's Name (First, Middle, La			יארו	cucive r		Name (First, Midd					
Ĕ	ntal l ed or	Be	John Lovey						,		,,			
Š	d Me nark natic	To .	19a. Informant's Name/Relationshi			Ob Mailia	g Address (Street		<u>ie Mae M</u>			4.4.4. 7iu		
2	d 2 sl th an 7 is r traur				'		•				,		,	0.4
ָר ב	1 and Healt 9m 2	1	Christopher J. M 20a. Method of Disposition	cGath/Son	T20h Place		526 Monto	- :	Date	200	Sprin Location - C			04
5	nt of		1 🙀 Burial 2 □ Cremation 🤇		1		sition (Name of natory or other place		ept. 18,			•		
	t. Partmer		4 □ Donation 5 □ Other (Spe		St.		ph's Ceme		2007		umbus,		10	
Dalitillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee		F 1	Name and Addre rancis J	Collin	ns Funer	al H	ome Ir	ic.		
	462 60		23a. Part1. Exter the disease, or c	Dog A			00 Univer				ver Sr	rin		
			shock, or heart failure. List o	ally one cause on each line	ne death. D	o not ente	er the mode of dylr	ng, such as card	diac or respiratory	arrest,		100	Approximate Interval Bety Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a.Failure T	to Thr	ive							Months	
	/Medical Examiner		resulting in deality	Due to (or as a	consequenc	ce of):								
	LAUIIIIIICI	_	Sequentially list conditions,	b.Multi-Org			2						Months	
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Errier Unuerlying Cause (Disease or injury that initiated events	Due to (or as a	consequent	ce orj:							• •	
	ecut and tran	Examiner	that initiated events resulting in death) Last	c. Dementia Due to (or as a	consequenc	na of):						_	Years	
ָבֻ ב	oe ex cian ourial	Ξ E		Due to (or as a	consequenc	ue oi).								
00/00	feath certificate be executed attending physician and I for use as the burial-transit	cian/Medical	•	d								+		
5	ding	/Me	IF FEMALE:	23c. If yes, outcome p	f pregnancy	,			***					
ב	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal dea	ath 3□	Ectopic pregnancy Other (specify) _	у			23d. Date Mont		,	ear/
5	0 0	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□Unknown	ine or dear	1 3	Totner (specify) _		-	-				
Ŀ	that the	Physi	Part II. Other significant condition	s contributing to death but	not resulting	a in the ur	nderlying cause giv	en in Part I.	23e. Di	d tobacco	use contrib	ute to t	he cause of de	eath?
Ų,	ires t signe	by	Arthritis			3	,,				2 □ No 3			Jnknown
5	requ	mpleted	***************************************								1			-
בַּ	e 2 s	힐					·····		24a. Wa au	topsy	24b. W	ere auto or to co	psy findings a mpletion of ca	available ause of
	The cate pag	So							1 ☐ Yes	rformed?		ath? Yes	2□ No	
150	cian; ertific	Be	25. Was case referred to medical examiner?						Death (Check onl	y one)				
5	hysi this c	2	1 ☐ Yes 2☐ No	Hospital: 1 ☐ Inpatien		Outpatien		4 M Nursin	g Home 5□Re	esidence	6 □Other	(Specif	y)	
_	Attending Physician: The law requires that the d ar death. rector: After this certificate has been signed by the by the funeral director, page 2 should be detached	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	<i>Year)</i> 28t	b. Time of Injury	28c. Injur Wor	ry at rk?	28d. Describ	e how in	jury occurred	t		
2	tendleath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no	the				Yes 2 □ No						
2	or Att	Certification:	4 Homicide determin			, farm, stre	eet, factory, office		28f. Location City or 7	ı (Street : Го <mark>wп, St</mark> a	a <i>nd Number</i> ite)	or Rura	al Route Numi	ber,
2	ital c		-37											
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	(Check only 2 ☐ Medical E	Physician: To the best of xaminer: On the basis of e	examination	dge, death and/or inv	n occurred at the til vestigation, in my o	me, date and pl opinion, death o	ace, and due to the courred at the time	he cause ne, date a	(s) and man ind place, ar	ner as s id due t	tated. o the cause(s)
	the hin 2 the	Ned	29b. Signature and title of certifier	and manner state	ed.		200 Licens	o number		004 5	Note oimped	/hdo-akh	D V)	
	7 wit	~		· W-1.	0 -		29c. Licens	/ O C		290. L	Date signed	iviorith,	∟ay, rear)	
	5		* Kallia	My. LU	l1		1017	607		1.	1 d- () /		
			30. Name and addless of person w Raman Tuli, M. D		ath (Item 23a	a) (Type,	Print) , #B, Mt	. Raini	er. MD 2	0712				
				32. Polistrar	_		, 112, 110		,					
	Sta Registr		31. Date filed (Month, Day, Year) SEP 13	2007	s signature	1	sande)							
						10000	THE PERSON NAMED IN							

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:45 PM Sept 8, 2007 RICARDO G. MASON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14931 Athey Road, Burtonsville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1⊠M 2□F Jan.1,1945 Panama 62 Director 101-36-7445 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show 1 XYes 2 No must be notified Burtonsville MD Director Montgomery 28a-f the 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ŏ 14931 Athey Road 20866 U.S.A. Items 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XEYes 2 □ No If Yes, Give Year or Dates: 65-69 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify. 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington College (1-4or 5+) Elementary/Secondary (0-12) Hospital Ctr 4 Registered Nurse yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth G. Mason Miriam Quintyne ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any injury or other trau 14931 Athey Rd, Burtonsville, MD 20866 Camilla Mason (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3

☐ Removal from State Pinelawn Mem Park 9/17/07 Farmingdale, NY 4 □ Donation 5 □ Other (Specify) f Funeral Se 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 yrs Non-Hodgkins Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, iding physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3 Ectopic pregnancy Month in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown ed by ti signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day 5 ☐ Pending investigation Natural 1 Yes 2 No 2 Accident after death.

Director: / death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 9/13/07 D0041119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daya Sheel Sharma, M.D. 1400 Forest Glen Rd, #435, Silver Spring, MD

Date filed (Month. Day, Year)

32 Bookstar's Standards 31. Date filed (Month, Day, Year) State **SEP 1 3** Registrar

		1 - For State Registrar	State of Ma	ryland /	-	rtment tificate			lental Hy	giene Reg. No	2007	31161
Physic /Medi		Decedent's Name (First, Middle, Last) Robert Lawrence	Meyers						2. Date of De Month Sept	Day	2007	3. Time of Death 0400 M
Exami		4a. Facility Name (If not institution, give s Carroll Hospital	treet and number)			-	wn, or Loca estmin	ation of Death		4c.	County of Death)11
Funeral Director		5. Social Security Number 6. Sex		(In yrs. last	birthday) _ Yrs.	If Under 1 Months [Inder 24 Hrs. burs Min.	8. Date of Bi (Month, Di March	9 19	9. Birth	place (State or Foreign ntry) Wisconsi n
faryland show ed at	ŗ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To								10d. Inside City Limits 1
n with the M 3a or 28a-f st be notifii	al Director	MD Carrol 10e. Street and Number 3810 Beamers Ct	<u> </u>		Sykes	10f. Zip C	ode 21784				zen of What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		2. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			/as Deceder Yes, specify		ic Origin? (Spexican, Puerto	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
within 72 houene.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation completed) College (1-4or 5-		(Give k life. D		done during retired)	g most of work	ring	West	nd of Business/In inghouse hrup Gru	≘/
uld be filed Wental Hygi irked other rtic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Lawrence W. Meyers					18.	Mother's Name	e (First, Middle B. Bay	, Maiden		
and 2 sho salth and I n 27 is me er traums		19a. Informant's Name/Relationship (Type Debra Meyers/wife	e. Print)		3810	Beamei	s Ct		ral Route Numb sville,		Town, State, Zij 21 7 84) Code)
Pages 1 annual Ment of He ant: If iten ury or oth		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State			ition (Name atory or oth ch Cer			Date 7/2007		cation - City or To	own, State
permit. Depart import any inj		21. Signature of Funeration vice License			41	2 Wash	ningto	on Rd.,	and Cl Westm	inste		21157
Physician /Medical Examiner		23a. rt1. Fig. tile Isease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a	e consequen	ce of):	h c	Cors	nary f	hley	Dy	(eage	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
The law requires that the death certific ate has been signed by the attending plagge 2 should be detached for use as the state of the s	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome page 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal de	ath 3 🗆	Ectopic preg Other (spec				2	23d. Date of deliv Month	ery Day Year
quires that n signed by	þ	Part II. Other significant conditions con	tributing to death bu	t not resultin	g in the und	derlying cau	se given In	Part I.			se contribute to t	the cause of death?
: The law requir cate has been si	Completed								24a. Was auto perf		prior to co death?	opsy findings available ompletion of cause of
the Hospital or Attending Physician: The hospital or Attending Physician: Thin 24 hours after death. the Funeral Director: After this certificate mpietely filled in by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: Inpatier 28a. Date of Injur (Month, Day	y 28	Outpatient b. Time of Injury		Other:	☐ Nursing Ho	h <i>(Check only</i> ome 5□ Res 28d. Describe	idence 6	Other (Speci	(y)
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of inju building, etc	ry - At home . (Specify)	, farm, stre	et, factory, o	office		28f. Location City or To	Street and wn, State	d Number or Run	al Route Number,
the Hospit in 24 hour the Funera pletely filk	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best oner: On the basis of and manner sta	examination	dge, death and/or inv	estigation, in	n my opinio	n, death occur	and due to the rred at the time	cause(s) , date and	and manner as a place, and due f	stated. to the cause(s)
T S E E	Z	29b. Signature and title of certifier	Ju	2		29c. l	icense nun	1362	<u> </u>	29d. Date 5201	e signed (Month,	Day, Year) 14, 2007
W75			GERUSO	2	00 M	EMOR	JAL A	VENUE	WES	5TM1	NSTER	MD 2157
Sta Regist		31. Date filed (Month, Day, Year) SFP 1 4	2007	r's Signature	<i>K</i> .	brech	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	ate of ivialylatio /		ificate of		Reg.	2007	31162
19	Physic /Medi		1. Decedent's Name (First, Middle, Last) May Amr	or Martin	$\overline{}$			2. Date of Death Month	Day (Year 200	3. Time of Death
7 1	Exami		4a. Facility Name (If not institution, give street a	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		-	Location of Death	2/	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye Jan 10, 1	918 9. Birth	place (State or Foreign intry) ryland
	e Maryland a-f show tified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, Tov	wn or Loca		Vestminste	er		10d. Inside City Limits 1 Yes 2 □ No
:	ath with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 734 Charingworth Road	Į		10f. Zip Code	21158	10g.	Citizen of What Cou USA	ntry?
036	permit. Fages I and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 If Y	as Decedent Ever in U.S. med Forces?]Yes 2 ⊠ No /es, Give ar or Dates:		as Decedent of Hores, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
9200-51212	within 72 hd ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 8	oleted) 16a illege (1-4or 5+)	(Give kii life. DC	nt's Usual Occupa nd of work done of NOT use retired	during most of workin f)	16b	Sewing Fa	-
Maryland 2	uld be illed fental Hygi rked other ilc event, ti	To Be Co	17. Father's Name (<i>First, Middle, Last</i>) Frank Smerowski		1000	SELY WELL	18. Mother's Name Agnes G			
, Mary	and 2 sholl ealth and N n 27 is mai er traumai		19a Informant's Name/Relationship (Type. Pri Allen F. Martin, son		734 C	haringwo	and Number or Rural orth Road,			
baitimore,	. Fages I tment of He tant: If Iten jury or oth		20a. Method of Disposition 1 ⊠ Burial 2 □Cremation 3 □Remova 4 □Donation 5 □ Other (Specify)	Il from State 20b. Place of cemeter Glen	Have		ial 9/14/	2007 G	Location - City or T Len Burnie	e, MD
Pal	Depar Impor any in		21. Signature of Funeral Service Licensee	Carolin	91	Name and Addres Willis	ss of Facility Mye Street, W	ers-Durbon Jestminste	raw Funera er, MD 211	il Home 57
	hysician /Medical xaminer		23a. Part I. Enter the disease, or complications shook, or heart fallure. List only one caus immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do se on each line. Due to (or as a consequence		the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	5	niner	cause. Enter Underlying	Due to (or as a consequence	of);					
oorou,	incate be executed growing physician and as the burial-transit	ledical Examiner	triat initiated events	Due to (or as a consequence	of):					
The law requires that the doct become	After this certificate has been signed by the attending pluneral director, page 2 should be detached for use as t	Physician/Med	in the past 12 months?	es, outcome pf pregnancy]Live birth 2 □ Fetal death]Pregnant at time of death]Unknown		ctopic pregnancy other (specify)			23d. Date of deliv Month	ery Day Year
COLOS, T	en signed b	þ	Part II. Other significant conditions contributin	ig to death but not resulting i	n the unde	erlying cause give	en in Part I.	23e. Did tobacc	o use contribute to t	he cause of death? bably 4 ∐Unknown
اما تامن	ficate has be	Completed	25. Was asso referred to medical					24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of 2□ No
Or VII	this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	Inpatient 2 ER/Ou		3 DOA Othe	4 🗆 Nursing Hom		6 □Other (Specia	<i>fy)</i>
Attending	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	1 Natural 5 Pending investigation		Time of Injury arm, street		? Yes 2 □ No	3d. Describe how in	and Number or Rura	al Route Number,
Denital or	within 24 hours after dear To the Funeral Director; completely filled in by the		29a. Certifier 1 Certifying Physician:	To the best of my knowledge the basis of examination an	e, death o	ccurred at the tim	ne, date and place, ar	City or Town, Sta	(s) and manner as s	stated.
To the	within 24 To the F complete	Medical	one) and 29b. Signature and title of certifier	d manner stated.	>	29c. License	number		Date signed (Month,	
ィ	OH		30. Name and address of person who complete	d cause of death (Item 23a)	(Type, Pri		059943	50	plember	11,2007
	5 Sta		31. Date-filed (Month, Day, Year)	32. Régistrar's Signature	er f	JR Sui	e 307	vegtm12	wifer MC	221157
	Registr	ar	SEP 1 4 2007	Photos D	GOS	West of the second				

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No. 2007 3 6	53
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	eath M
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 217-28-5525 12 M 2 F 77 Yrs. Months Days Hours Min. 9 -8-19330 9. Birthplace (State or F Country) MD	oreign
	the Maryland 28a-f show colified at	ector	10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Inc. City and Number 10d. Street and Number 10d. City Tox Code 10d. City To	
	s 23e or	Funeral Director	10e. Street and Number 14702 National Pike 10f. Zip Code 21722 10g. Citizen of What Country? U.S.A	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Mental Hygiene 23 is narked other then "naturel", or Items 23e or 28a-7 show other traumatic event, the Madical Examinat must be notified at	b	3 □ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ₹ No Specify: Specify: White	
2121	filed within 72 Hygiene. rther then "na int, the Neufic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The DO NOT use retired	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, ILEM	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tra Leroy Munson Dolly Elizaboth Woodgock	
	1 and 2 sho Health and em 27 is ma ither trauma		19a. Informant's Name/Relationship (Type, Print) Rethabelle Munson wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14702 National Pike Clear Spring, MD 217	722
Baltimore,	Page nent o int: If iry or		2007	1D
Bal	permit. Pag Department Important: eny injury once.		22. Name and Address of Facility Donald Edwin Thompson Funeral Home, In	ıc
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition) AD 2 1732 ppr ximate Interval Betwee Onset and Death Cause (Final disease or condition)	
	/Medical Examiner	ier	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): A Consequence of the consequ	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Acute my o Cardial intercept on Due to (or as a consequence of): Due to (or as a consequence of):	7
.O. Box 68	at the death certific by the attending pl tached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	r
s, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	
H	The law ate has b page 2 si	e Completed	24a. Was an autopsy findings avair prior to completion of cause death? 1	ilable e of
of	ding Phys h. After this funeral dir	To B	examiner? 1	
-	el or Attenos after deatl	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To the within 2 To the complete		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	
51	13+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tava School MD 130 w High St Haucach MV 21	750
	Sta Registr	- 12"	31. Date filed (Month, Day, Year) SEP 18 2007 32. Begistrar's Signature SEP 18 2007	

Division or Vital Records, P.O. Box 68760,

Examiner **Funeral** Director with the Maryland items 23a or 28a-f show ner must be notified at Pages 1 and 2 should be filed within 72 hours after death variet for Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s mart; If item 27 is marked other than "natural", or items Lasaminer must ury or other traumatic event, the Medicial Examiner must Baltimore, Maryland 21215-0036 Department of Health Important: If item 27 any Injury or other tr once. Physician /Medical Examiner The law requires that the death certificate be executed burial-trar the attending for use as ed by the a been signed be should be deta certificate Attending Physician: ector, To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire Certification: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) 00062327 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREE 3H-4 21740 MILL MAUGUSTOWN, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 8

State Registrar

5

29b. Signature and title of certifier

RICHARD 31. Date filed (Month, Day, Year)

and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICUM,

Desti

NC it in

32. Registrar's Signature

29c. License number

D31826

M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Amended #2 per Phy.gc 9/18/0 Pertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Brandon Michael Proffitt 09 2007 8:36a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 127 Conestoga Road Middle River If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 12 M 2 □ F 23 07/16/1984 Maryland 213-25-3603 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Tyyes 2 □ No Directo Maryland Baltimore Middle_River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S. 127 Conestoga Road Funeral . Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give 2003—Year or Dates: 2007 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Air National College (1-4or 5+) Elementary/Secondary (0-12) A-10 Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donna Leigh Edwards Bradley Joseph Proffitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3709 37th Avenue, Cottage City, MD 20722 Donna Proffitt/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 9/18/2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 20722 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

a.Self-inflicated Guy Shot wound to have Creating in death) Approximate interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month signed by the atte Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 | Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 1 Yes Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA c 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation Shot tember 12267 836 A 1 ☐ Yes 2 No Suicide Gun to head 2 Accident the Funeral Director: npletely filled in by the Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 127 Connection Rock 3 Suicide 4 Homicide Marykind Middle River home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Pay, Year)

là 32. Registrar's 8

pleted cause of death (Item 23a) (Type, Print)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA 2434 W. BELVEDERE AVE, BALTIMOR SEP 1 4 2007 31. Date filed (Month,

29b. Signature and title of certifier



Registrar

D0053928

BALTIMORE

BELLUM, MD

29d. Date signed (Month, Day, Year) 09/10/07

State Registrar

31. Date filed (Month, Day, Year) SEP 1 3 2007

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)
Susan Hasselquist, M.D. GWUH 900 23rd Street, N.W. Washington, D.C. 20037 32. Resistrar's Signature Ben

Division or Vital Records, P.O. Box 68760,

		State of Maryland / Depa			•
		a Por	rtificate of Dea	•	Reg. No 2007 31169
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Year
/Medic	cal	George Thomas Parker 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca		per 11, 2007 1:13 p M
Examin	ier	Montgomery General Hospital	Olnev		Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If U	Under 24 Hrs. 8. Date of Bir ours Min. (Month, Da	th 9. Birthplace (State or Foreign
Director		080-05-7948 94 Usual Residence of Decedent		Dec. 31	, 1912 New York
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	_	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
the Ma 28a-f s	Director		er Spring		1 □Yes 2 No
aa or 3		3701 International Drive, #509	10f. Zip Code 20906		10g. Citizen of What Country?
death	Funeral			nic Origin? (Specify Yes or No exican, Puerto Rican, etc.)	USA 14. Race - American Indian,
s after , or ite amine	by Fu	1 Never Married 2 Married 1 Yes 2 No	- 14	ecify:	Black, White, etc. Specify: White
tural'		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent	lent's Usual Occupation		16b. Kind of Business/Industry
thin 72 e. an "na Medi	Completed	(Specify only highest grade completed) (Give life. I	kind of work done during DO NOT use retired)	g most of working	
led wi lygien her th nt, the		4 Clie	mist	Matheda Name (First 64:24)	Private Industry
d be fi	Be C	17. Father's Name (First, Middle, Last)		Mother's Name (First, Middle	
shoul and Me s mark umati	ပ	Clarence Arthur Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailir		Clizabeth Fran Number or Rural Route Numb	er, City or Town, State, Zip Cole 906
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.					#509, Silver Spring, MD
ges 1 if of H if Iter or oth	,	I I I I I I I I I I I I I I I I I I I	natory or other place)	Date Sept. 12,	20c. Location - City or Town, State
iit. Pa artmen ortant; injury			tan Cremato	2007	Alexandria, Virginia
Depa Impo any i				Facility Collins Funera	1 Home Inc.
		23a. Part1. Inter the disease, or complications that aused the death. Do not ent shock, heart failure. List only one cause on each line.			
Physician		Immediate Cause (Final disease or condition			Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	-		
g Alva No. 2	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
be executed ician and burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):			
		d			
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e deat he attr	sicia]Ectopic pregnancy] Other <i>(sp</i> ec <i>ify)</i>		Month Day Year
w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in F	Part I. 23e. Did t	obacco use contribute to the cause of death?
quires n signe ald be	d by				Yes 2 No 3 Probably 4 Unknown
aw rec Is bee	plete			24a. Was	
The I	Completed			auto perfo 1∐ Yes	psy prior to completion of cause of death? 2 1 Yes 2 No
Ician: certific ector,	Be	25. Was case referred to medical examiner?		Place of Death (Check only of	one)
Phys er this eral dir	: To	27. Manner of Death 28a. Date of Injury 28b. Time of		☐ Nursing Home 5 ☐ Resi 28d. Describe	dence 6 Other (Specify) how injury occurred
ath. rr: Afte	Certification:	tural 5 Pending (Month, Day Year) Injury 2 Accident investigation Injury	Work? 1 ☐ Yes	2 🗆 No	
or Atte	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, strubuilding, etc. (Specify)	eet, factory, office	28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
pital o		29a. Certifier Certifying Physician: To the best of my knowledge, death	a accurred at the time, da	ate and place, and due to the	causa(s) and manner as stated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion	n, death occurred at the time,	date and place, and due to the cause(s)
Withir To th	Me	29b. Signature and title of certifie	29c. License num	nber	29d. Date signed (Month, Day, Year)
4(2)			D0063	3196	7/11/07
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Prior X	ine Museu	My mass
Sta	te	31. Date filed (Monts En Yaar) 3 2007 32. Legistrar's Signature	I vollb M	THE CINEY	11/2000
Registr		July 2001 Steen & A	asset .		

Amended Item 20b per F.D. 09/17/2007 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	of Marylan	-		nt of H te of L		Mental	Hygie _{Reg.}	ne N20	07	31171
			Decedent's Name (First, Middle, Las	t)						2. Date of	f Death	Dav	Year	3. Time of Death
	Physicia /Medic	_	Mary Ruth Shaffer							Septe			2007	6:52 A M
	Examin		4a. Facility Name (If not institution, give Long View Nursing		ımber)		,	Town, or chest	Location of Dea	ath		4c. County		
	Funeral Director		5. Social Security Number 6. Se 213–60–3703	ex □ M 2 X F	7. Age (In yrs.	last birthday) 90 Yrs.	If Unde Months	Days	If Under 24 Hr Hours Mir	8. Date of (Month) Aug.	i, Day, Ye	1917	Cour	place (State or Foreign ntry) yland
	2 ,		Usual Residence of Decedent		10c Cit	y, Town or Lo	cation						1	I0d. Inside City Limits
	show	2	10a. State 10b. County Maryland Carroll			mpstea								1 □ Yes 2X No
	28a-f	Director	10e. Street and Number			<u>r</u>		p Code			10g.	Citizen of V	What Cou	ntry?
ž	3a or		4012 Dana Court				2	1074			Un	ited s	State	es
1	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13. V	Nas Dece	dent of Hi	spanic Origin? (n, Mexican, Pue	Specify Yes o	r No-		e - Americ	ean Indian,
٥	or ite		1 Never Married 2 Married	if Yes, G	orces? 2 🔼 No ive	- 1	1 □ Yes		Specify:		-7		whi	
5-0036	nours arer bearn with the invaryanto tural", or Items 23a or 28a-f show al Examiner must be notified at	d by	3 X Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or [Dates:	16a. Deced	lant's He	ial Occupa	ation		16	b. Kind of B		
ည်	"naf	Completed	(Specify only highest gra	de completed,		(Give life. L	kind of wo	ork done o	during most of w	orking				
717	Hygiene. Sther than "na ent, the Medic	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Hom	emak	er		···	0	wn hor	ne 	
פר		Bec	17. Father's Name (First, Middle, Last) William Wisner						18. Mother's Na		ddle, Mai	iden Surnan	ne)	
yian	Ment arked atic e	2				1			Mary Ga					
Mar	ind z should be in the and Mental h 27 is marked of r traumatic even		19a. Informant's Name/Relationship (7) Dorothy Ruth Toups		ghter			s (Street a a Cou	and Number or I	mpstea				
ar 🤻	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition			Place of Disper			torst	Date		c. Location		
ם ים	rages nent of l ant: if it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			emetery; cres Chmoun				t. 17 2007	Ha	ampste	ead,	Maryland
Baltimore,	permit. rages Department of Important: If it any Injury or o	ŀ	21. Signature of Funeral Service Lice			22	. Name a	nd Addres	ss of Facility	Eline :	Fune	ral Ho	me	
ď	on in De		Slan C. to	ms	M01	072 9	34 S	. Mai	n Stree	t Ha	mpste	ead, N	1D 21	074
	1-5		23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that one cause on	caused the deat each line.	h. Do not ent	er the mo	de of dyin	g, such as cardi	ac or respirate	ory arrest	1		Approximate Interval Between Onset and Death
P	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Cir	ebror	usent	ar	ac	ceden	t				48h
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	- 1	14	alar h	and	14			25- bara
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq		z v	rase	were n					15 yrs
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Pa	chuns	ins D	Irse	nse						15 yrs
o	an an arial-tr		resulting in death) Last	Due to	(or as a conseq	uence of):								
09/8	The law requires that the death certificate be executed the has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	dical		d										
Š X	attending p	/Mec	IF FEMALE:	23c If yes or	utcome pf pregn	ancv						234 Da	te of deliv	95/
ROX	attende for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 ☐ Feta	aldeath 3□	Ectopic p	oregnancy specify)			_		onth	Day Year
oj [y the	Physician/Me	1 ☐ Yes 2 ☑ 100 No. 9 ☐ Unknown	9□Unk										
رن ح	ures that the de isigned by the a id be detached f	by Pt	Part II. Other significant conditions of	ontributing to	death but not res	ulting in the u	nderlying	cause give	en in Part i.	23e.	Did tobac			the cause of death?
ğ	been sig									-	1 Yes	2 □ N o	3 Pro	bably 4 □Unknown
ပ္တ	as be	Completed								-	Was an autopsy		prior to co	opsy findings available ompletion of cause of
		Con								10 \	performe es 2	J-No	death? 1 ☐ Yes	2 □ No
	nysician: nis certifica director, i	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of D				(0	
		2	1 ☐ Yes 2 ☐ No	1 _	of injury	ER/Outpatier 28b. Time of		28c. injun Work	4 Hoursing	Home 5 28d. Desc		injury occur		<u>(v)</u>
	r this or		27. Manner of Death	Zoa. Date		Injury								
or Vital	aing Pny i. After this funeral d		1 ■Natural 5 □ Pending	(Mo	nth, Day Year)		M	' ' '	Yes 2 ☐ No					
JIVISION OF VITAL	aing Pny i. After this funeral d		1 ➡Naturai 5 ☐ Pending	(Mo	ee of injury - At h	ome, farm, str			Yes 2∐No	28f. Locat City o	ion (Street or Town, S	et and Numi State)	ber or Rur	al Route Number,
JIVISION OF VITAL	aing Pny i. After this funeral d	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 1 Certifying Ph 2 Medical Exam	28e. Place built	e of injury - At h ding, etc. (Speci de best of my kno basis of examina	ome, farm, str	eet, facto	ry, office	me, date and pla	City of	or Town, S	State) se(s) and m	anner as :	stated.
JIVISION OF VITAL	aing Pny i. After this funeral d		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 5 Pending investigation 6 Could not be determined	28e. Place built	e of injury - At h ding, etc. (Speci	ome, farm, str	eet, facto	ry, office	ne, date and pla	City of	o the cau	State) se(s) and m	anner as and due	stated. to the cause(s)
JIVISION OF VITAL	To the Prospita of Attending Priys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 1 Certifying Ph 2 Medical Exam	28e. Place built	e of injury - At h ding, etc. (Speci de best of my kno basis of examina	ome, farm, str	eet, facto	ry, office d at the tin	ne, date and pla	City of	o the cau	se(s) and me and place	anner as and due	stated. to the cause(s)
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JIVISION OF VITAL	aing Pny i. After this funeral d	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the and ma	te of injury - At h ding, etc. (Speci ne best of my km basis of examina nner stated.	ome, farm, str fy) owledge, death ation and/or in	eet, facto	d at the tin on, in my o	ne, date and pla	City of the courred at the	o the cau time, date	se(s) and me and place	anner as and due	stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. 13^{pay} 2007 FRANCES LEE SHELHORSE 4:03 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye Harch 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 212-38-0550 67 1940 Director Mary land Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show. 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 338 South Jefferson Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2X No Specify <u>^</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester S. Testerman Lacy L. Lassiter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 South Jefferson Street, Frederick, MD 21701 John Shelhorse / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 9/14/07 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens ROBERT and Address of Facility & SON FUNERAL HOMES, P.A. Tut 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or compliant ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): OVATION month /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE use lf yes, outcome pf pregnancy 1⊑Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No tupertention 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas ane mi autopsy certificate I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1XNatural hours after death. 2 Accident 1 ☐ Yes 2 ☐ No d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

one) 29b. Signatu

and title of certifier

31. Date filed (Month SEP) 4

Hiren N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Thomas

2

Baltimore,

Division or Vital Records, P.O. Box 68760

Shah

29c. License number

29d. Date signed (Month, Day, Year,

Fredorich mo dito2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death SEPTEMBER 11 **Physician** 2007 7:00 A SANCHEZ DANILO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)
Aug. 30, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 12X M 2□ F 1923 Florida 84 Director 261-16-2300 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 No Director Carro11 Mt. Airy Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21771 6420 Ridge Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ⊠Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify. Specify: White þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Art Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caridad Lacedonia Ricardo Sanchez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 225 N. May Street Southern Pines, NC 28387 Suzanne Coleman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 14, 2007 Frederick, Maryland 5 ☐ Other (Specify) 4 ☐ Dopation Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. He to only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ardiopulmonary /Medical Due to (or as a consequence of): Examiner myperkalemia Sequentially list conditions, it any line cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of): Examiner certificate be executed burial-transi acidosis metabolic and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 NO 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident

Box 68760, Division or Vital Records, P.O. After this or Attending death. To the Hospital

funeral director, within 24 hours after death To the Funeral Director: the

29b. Signature and title of certifler

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

H65835

07 12

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. Seventh Street Frederick, Maryland 21701 Rohan Rengen, M.D.

31. Date filed (Month, Day, Year) SEP 1 4 2001

3 Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

(Check only

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	tate of Marylan		artment of F			gien 200	7 31174
	Physici /Medic		Decedent's Name (First, Middle, Last) William Monahan	Singer					per 15, 2	
	Examin Funeral		4a. Facility Name (If not institution, give stre Jacob's Well Assi. 5. Social Security Number 6. Sex.	sted Living 7. Age (In yrs.		4b. City, Town, o Rel A- If Under 1 Year Months Days		8. Date of Birth (Month, Day	/, Year)	
	Director would		176–03–8819 Usual Residence of Decedent 10a. State 10b. County	89	Yrs. y, Town or Lo	cation		2/22/19	918 1	Pennsylvania 10d. Inside City Limits
	with the Ma la or 28a-f	Director	MD Harford 10e. Street and Number		Aberde	10f. Zip Code			10g. Citizen of Wh	1 ☐ Yes 2 ☑ No nat Country?
9036	72 hours after death with the Maryland 'natural', or iteme 23a or 28e-f ehow bigel Exatural must be trufffed at	d by Funeral	1935 Bennett Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 12€ Yes 2 ☐ No If Yes, Give Year or Dates: WWII		21001 Was Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Black,	- American Indian, White, etc. White
Maryland 21215-0036	d within 72 jiene. r than "nai	Completed	12	on ompleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w d) binder			nting
aryland	d 2 should be filed th and Mental Hyger is marked other traumatic event,	To Be	 Father's Name (First, Middle, Last) Joe Monahan Informant's Name/Relationship (Type, 	Print)	19b. Mailir	ng Address (Street	Julia	ame (First, Middle, Heller Rural Route Numbe		
Baltimore, Ma	ss 1 and of Health litem 27 rother ti		John R. Krebs (Neg 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 ☑ Other (Specify)	20b. F	Place of Dispo cemetery, crer	Bennett sition (Name of natory or other place Park Cem	ce)	Aberdeen, Date 0/07		ity or Town, State
Balti	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service Licensee	surgle	shey 22	Name and Addre Tarring- Aberdeer	ss of Facility Cargo F Maryl	uneral Ho and 2100	me, P.A. 1-3399	Approximate
8760,	Physician /Medical Examine putaicien and physicien and physicien and ithe pritains it is the pritain of the pri	ai Examiner	shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death) a	ause on each line.	uence of):	Pneum	40%			Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate te has been signed by the ettending physogge 2 should be detached for use as the	Physiclan/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn: 1 Live birth 2 Feta 4 Pregnant at time of c	il death 3	Ectopic pregnancy	,		23d. Date Mont	
cords, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contrib	-1 7 (eliting in the u	nderlying cause gw	en in Part I.	23e. Did to	res 22 No 3	oute to the cause of death? B Probably 4 Unknown ere autopsy findings available
ital Re		se Completed	25. Was case referred to medical				26. Place of E	autop perfor 1 Yes	rmed? de 200 No 1	or to completion of cause of ath? ☐ Yes 2 ☐ No
Division of Vital Records,	ing Phys h. After this i funeral dir	ation: To B	1 Aatural 5 ☐ Pending investigation	pital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui	4 Nursing	Home 5 Resid	dence 6 Other now injury occurred	(Specify) 25 STCG
Divis		i Certification:	4 Homicide	28e. Place of Injury - At h building, etc. (Special	5)			City or Ton	vn, State)	r or Rural Route Number,
	o the Hospital	Medical		en: To the best of my kno : On the basis of examina and manner stated.			pinion, death oc	curred at the time,	date and place, ar	
	10+1		30. Name and address of person who comp	Multipleted cause of death (Iter	n 23a) (Tvoa.	Print)	41069		Septemi	ber 17,2007
	Sta Registr		DR STANLEY KM 31. Date filed (Month Street) 20	1 12 0	Busne!	Range WY	#102	Edgen	M book	0 21040

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

death with the Maryland

Hospital or Attending Physician: after death.

State

5 31. Date filed (Month, Day, Year)

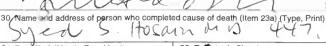
1 4 2007

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical



29c. License number 179502

11 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

East Main sheet Westherster

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 21 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ASTER LEE THORNE COTEMBEY 10, 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 DXM 2 □ F Director 239-48-8845 06/25/1935 NORTH CAROLINA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD PRINCE GEORGE'S must be notified LANHAM Director XX Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4228 KINMOUNT ROAD 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates 1954-1958 1 Never Married 2 Married , or 1 ☐ Yes XXNo Specify: SpecifyBLACK þ 3 □ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH LABORER jes 1 and 2 should be filed v to Health and Mental Hygie If item 27 is marked other to other traumatic event, the PRIVATE marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE THORNE CARRIE GRAY ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN PARKS/SISTER 4228 KINMOUNT ROAD LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; If it any injury or conce, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERAN'S 09/17/2007 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pinal disease or condition resulting in death) **Physician** Intracerebral Hemorrhage selas /Medical Due to (or as a consequence of): Examiner Teriosdenote Candiovascular Disease Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical aftending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

P.O. Box 68760, Records, Division or Vital

law requires that the death certificate be executed Physician: ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t completely To the

State Registrar 29b. Signature and title of certifler

29c, License number

29d. Date signed (Month. Dav. Year)

September 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4208 QUEENSBURY Rd HyGITSUITE MI) 20781

The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, the as attending properties of ned by the at detached for been signed be should be deta certificate has birector, page 2 s To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours a To the Funeral [

Funeral

Director

28a-f show

23a or

Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. The mark of the 27 is marked other than "natural", or items 233 ant: If item 27 is marked other than "natural", or thems 233 ury or other traumatic event, the Medicial Examiner must

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tn once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner must be notified at

with the Maryland

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Street Hagerstone MD 21740

completed cause of death (Item 23a) (Type, Print)

and manner stated.

368

SEP 1 31. Date filed (Month

32. Registrar's Signature

			1 - State of Mary State of Mary		artment of F rtificate of			0.0	07 31178		
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Decedent's Name (First, Middle, Last)								
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			r Location of Death	Sept.	4c. County	11 2007 6:40 A ^M 4c. County of Death Anne Arundel		
8	Funeral Director			n yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) July 30	Year)	9. Birthplace (State or Foreign Country) Maryland		
ore, maryland 21215-	/land ow at			Oc. City, Town or Lo	cation			,	10d. Inside City Limits		
	he Mary 28a-f sh otifled	ector	Maryland Anne Arundel		1 □ Yes ②□X No						
	tth with t 23a or 2 ust be n	Funeral Director	10e. Street and Number 1678 Homewood Landing Road		10f. Zip Code	21409	1	0g. Citizen of W	/hat Country? .S.A.		
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must, be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ◯ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 【XNo	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		e - American Indian, k, White, etc. White		
	"natura	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king	16b. Kind of Bus	siness/Industry		
	be filed within 72 ho ital Hygiene. d other than "natu event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Instructo	*	I	Baltimor	re Public Sch.		
		To Be (17. Father's Name (<i>First, Middle, Last</i>) Howard Harker				e (First, Middle, I Schinde)		3)		
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Dallas B. Usry/son	1668		and Number or Ru Landing	ral Route Number Road Ar	City or Town, S	State, Zip Code) 5 , MD 21409		
	0 0		1 ☐ Burial ② Cremation 3 ☐ Removal from State		natory or other plac	e)			City or Town, State		
Daillmor	permit, Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	22.	. Name and Addres	ss of Facility Jo	nn M. Tay	lor Fun	od, Maryland meral Home olis, MD 21401		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a co	death. Do not ente	er the mode of dyin	g, such as cardiac みしとしへy	or respiratory arre		Approximate Interval Between Onset and Death 2 Wilkins		
	Examiner	_	Cmarc	2871 Viz	Hamma P	THILVAR	5+Yimas				
,	icate be executed physician and the burial-transit	edical Examiner		noron	y FAIL	UNE		3 WEEKS			
00/00,	ficate be physici s the bu	edical	d								
O. DOX	Attending Physician: The law requires that the death certific rector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown 23c. If yes, outcome pf pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year		
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The United States of Alice and Alice	aw requ	Completed					24a. Was an		3 Probably 4 Unknown dere autopsy findings available		
	n: The I ficate ha r, page 3						autopsy	pri led? de	for to completion of cause of eath? □Yes 2□No		
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	nding Pl th. : After tl s funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	ar) 28b. Time of Injury	28c. Injury Work		28d. Describe ho				
	after deat Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - building, etc. (S)	 At home, farm, stree pecify)		.00 2010	28f. Location (Str City or Town,	eet and Number State)	r or Rural Route Number,		
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one and manner stated. Certifying Physician: To the best of my one and manner stated.	/ knowledge, death mination and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mani ite and place, an	ner as stated. nd due to the cause(s)		
	vithin To the	Me -	29b. Signature and title of certifier		29c. License			_	(Month, Day, Year)		
	12-4	2	30. Name and address of person who completed cause of death	(Item 23a) (Type, P	Do	8118)हि । जिल्ला	Ain 11, 2007		
	W.Co.		STANCY WATKINS MO 9	100 BBST	-6 ATE N	O BNI	VMORIS	mo z	1401		
	Stat Registra	٠	31. Date filed (Month, Day, Year) 32 Registrar's S	Signature	. مد						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Lois Ann Wolford 10:30 AM /Medical Jeptember 13 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County Hagerstown 5. Social Security Number 6. Sex if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) march 23 1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Days Hours 220-28-3547 78 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Hagerstown Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13224 Greencastle Pike 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Doctor's Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer T. Hixon Mary R. Kellner Hixon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald T. Wolford - husband 13224 Greencastle Pike Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9-15-2007 Cedar Lawn Mem Park Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Musto 1331 Fastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respirat by arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of) Examiner Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 22 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the negree within 24 hours after death.

To the Funeral Director: After this ce

Baltimore, Maryland 21215-0036

5H-4

State Registrar

31. Date filed (Month, Day, Year) SEP 1

29b. Signature and title of certifier

32. Regiotrar's Signature 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		ľ	For State Registrar	State	of Marylar		artment rtificate					giene 0 C	7	311	80	
	Physici		Decedent's Name (First, Middent's Hong								2. Date of De.	Day / -	Year 7	3. Time of 1		
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City,	Town, or	Location of	of Death		4c. County				
н	X	•	Holy Cross Reha	d & Nursing	Center		Bur	tonsv	ville			M	ontgom	ery		
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp Coun		^r Foreign	
L	Director		577-64-5178	TIXJ M ZLJ F	87	Yrs.					January	28,1920		China		
	pur *		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Ci	ty, Town or Lo	cation						1	0d. Inside Cit	y Limits	
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	the N	ect	10e. Street and Number	ontgomery			10f. Zip		KVIII			10g. Citizen of V	Vhat Coun	try?		
	with with	<u>ā</u>	11100 Rock Road 20852									S.A.				
	within 72 hours after deeth with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Sp	ecify Yes or No	- 14. Rac	e - Americ			
(0	r iten	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerio Hid					Rican, etc.)		k, White,	etc.					
9	al', o Exar		3 ☐ Widowed 4 ☐ Divorce	d If Yes, 0 Year or	Sive Dates:		1∟Yes 2	Z LAI NO	Ѕреспу:			Specify	Asian			
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2	ygier ygier her th				4		Restau	rant		aria Niama	o (Eirot Middle		staura	int		
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3	ould I Mer narke	2	Wah Yan			10h Maili	na Addrono	(Stroot n	and Alumbi			Tam er, City or Town,	State Zin	Codel		
Baltimore, Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/Relation			-	_				e, Maryla		Diaro, Esp	0000)		
	s 1 and 2. of Health au item 27 is		So C. Yee - Spo	use	20b.	Place of Dispo	sition (Nan	ne of			Date	20c. Location -	City or To	wn, State		
	ages ont of t: if it		1 Burial 2 ☐ Cremation		m State	cemetery, cre rt Linco				9/15	/2007	Brentwo	od Ma	rvland		
를	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentai Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once.		*4 □Donation 5 □ Other	1	1	2:	2. Name an	d Addres	s of Facili	ty			5u, 11u	Lyland		
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of Vital Records, P.O. Box 68760,	that the death certificate be executed A detached for use as the burial-transit The detached for use as the burial-transit		23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										ween			
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	o (or as a consec											
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	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condi HUPERTEN.		outing to death but not resulting in the underlying cause given in			en in Part I	l.		olid tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Usknown			/		
	The ate h page	Completed									24a. Was auto perfo 1 Yes	psy prmed?	Were auto prior to co death?	psy findings a npletion of ca 2 No	available ause of	
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medic examiner?					0.1		e of Deat	h (Check only o	one)				
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Division	or Al efter of Direction by	Certification:	4 Homicide deter	mined 200. Fla	Iding, etc. (Speci	ify)	reet, ractory	, onice			City or To	wn, State)				
	To the Hospitel or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C									tated. the cause(s	:)				
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			30. Name and address of person	AKHA	NI, 28	35 5	Print)	4 1	TVE,	Su	ITE 20	3 BA	eto	MD21	208	
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13	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic	al	LEON R. YOURTEE 4a. Facility Name (If not institution, give street and number)	nel	4h City Town or	Location of Death	Sept.	16	2007	858 AM	_
	Examin	er	2339 YOURTEE ROAD	er)		OWNSVILLI	Ŧ,	WASHINGTON			
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)			8 Date of Bir	h v. Year)		ace (State or Foreign	_
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				100	d. Inside City Limits	_
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	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Countr	y?	_
	s 23a		2339 YOURTEE ROAD 11 Marital Status 12. Was Decede	ent Even in II S 10	Was Deceded of III	21715	anife. Van au Na	T 14	U.S.A Race - America		_
	fter de	Funeral	Armed Force	□No 1942-	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		Black, White, et		
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Date	s: 1968	1 ☐ Yes 2 🔀 No	Specify:		Si	pecify: WH	ITE	
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ylan		일	JUSTICE LEON YOURTEE			OLIVE A	HALT				_
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e)	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		MICHAEL W. YOURTEE/SON 20a. Method of Disposition		1 YOURTEE osition (Name of ematory or other place		COWNSVII		MARYLAND ation - City or Tow		-
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Baitimore,	permit. Pag Departmen Important: any injury once.		21. Signature of united service Licensee	2	22. Name and Addres	ss of Facility			tional P		
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0	nding Ph ith. r: After thi e funeral	ation	1 ☑ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury		k? Yes 2 ☐ No					
UIVISION	r Attendi er death. irector: A i by the fu	Certification:		injury - At home, farm, st , etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Number or Rural	Route Number,	Ī
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	e Hos 24 ho E Fune etely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the business and manner and manner.	s of examination and/or i	nvestigation, in my o	ne, date and place ppinion, death occu	rred at the time,	date and p	place, and due to	the cause(s)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date	signed (Month, D	Jay, Year)	_
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^	16-10-1		30. Name and address of person who completed cause	of death (Item 23a) (Type	, Print)	11.10		L	4	wa mo	Ī
	Sta	te	31. Date filed (Month, Day, Year) 32. Reg	of death (Item 23a) (Type	11110 1	redical	carrio	11 1	125000 h	WA GPID	_
	Registr		SEP 18 2007	Jam B. A	JOSH SI						

		1 - State Registrar		artment of Health a artificate of Death		Reg. No. 2	
Physic /Medi		1. Decedent's Name (First, Middle, Last) Bertie Irene	Zarcone		2. Date of Do Month Septem	ber 10,	2007 3. Time of Death 11:23 a M
Exami		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Annapolis	of Death		nty of Death Arunde1
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 F 7. Age	(In yrs. last birthday, 69 Yrs.		Min (Month D	rth	Birthplace (State or Foreign Country)
Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arunde1	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23a or 28a st be notif	al Director	10e. Street and Number 1492 Velmeade Road	Davidson	10f. Zip Code 21035		•	of What Country? States
If id Z Z 3-0030 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ ★Nortes Year or Dates:	ver in U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:		0- 14. F E Spe	ace - American Indian, Black, White, etc. cify: White
ed within 72 hours afr giene. er than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	edent's Usual Occupation e kind of work done during mos DO NOT use retired)	et of working	1 / \	STORE
d 2 should be filed tth and Mental Hygi ?7 Is marked other traumatic event, ti	To Be C	17. Father's Name (First, Middle, Last) Richard A. Corcoran	1		nor Louise		name)
C = 14 F	1	19a. Informant's Name/Relationship (Type. Print) Lindy Haas (daughter)	1492	ing Address (Street and Number Velmeade Rd.		lle, Ma	ryland 21035
permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i once.		20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Cemet	ematory or other place), am Veteran's erv	Sept 13,	Che1te	n - City or Town, State
permit Depart Import any in		21. Signature of Punisal Service Licensee M00		22. Name and Address of Facili 2 Hudson St.,			Cremation Servi
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ificate be executed g physician and as the burial-transit	edical Examiner	that initiated events c.	consequence of):				
The law requires that the death certific the has been signed by the attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			Date of delivery Month Day Year
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Hospita 4 hours Funeral	ledical C	29a. Certifier (Check only one) 1 ertifying Physician: To the best of and manner state and manner state.	examination and/or i				
To the within 2	M	29b. Signature and title of periffer		29c. License number	97	29d. Date sig	ned (Month, Day, Year)
1010		21 Date filed (Month Day Vear) 32 Begistra	ND An	re Avundel Me	died coul	Ann	apolis MD zitc
Sta Regist	rar	SEP 1 2 2007	J JE A	barle			

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De	bbie Andersoi		State of Maryland / Departm 1-For State Certific	ent of Healtl ate of Death		Mental Hy		. No. 20	07 311
	Physicia	an/	1. Decedent's Name (First, Middle,Last) DEBRA ANN DAVIS ANDERSON Debra	1	_	1	2. Date of Death Month September		3. Time of Death 0632 hrs
IVI C	edical Exami	ner	4a. Facility Name (if not institution, give street and number)	Ann Anderson 4b. City, To		cation of Death	September	25, 2007 4c. County of Dea	
A.			9420 Route # 1	Jessu		a l		Howard	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 217 +80 +9202 1 M 2 X F 45	rthday) If Under Months Yrs.		If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. B 961 Fore	
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location					10d. Inside City Limi
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5	e Maryland or 28a-f show ied at once.	Director	10e. Street and Number	10f. Zip (-	109	g. Citizen of What Co	untry?
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	72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceder If Yes, specify		inic Origin? (Spe Mexican, Puerto F		14. Race - Ame White, etc.	erican Indian, Black,
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	5-0C iled wit Hygien I other the M		17. Father's Name (First, Middle, Last)		-	.Mother's Name	•		
	D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	To Be	Joseph Louis Davis, Jr. 19a. Informant's Name/Relationship (Type, Print) 19	9b. Mailing Address	(Street a			boroski per, City or Town, Sta	ite, Zip Code)
	MD 2 nd 2 shou alth and 1 m 27 is r		Rosalie A. Davis (Mother)				Baltimor	re, Md. 21	206
	re, slar flee If ite		1X Burial 2 Cremation 3 Removal from State crema	of Disposition (Namatory or other place)		·		20c. Location - City	
	Baltimore, permit. Pages I ar Department of Hee important: If ite		4 Donation 5 Other Specify:	Haven Cen		·	-1-2007	Baltimor	e, Md.
	Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee	22. Name and a		Las	sahn Fu Baltimor	neral Hom e, Md. 21	e 236
64	Physician		23a. Part I. Enter the sease, or complications that caused the death. Do I failure. List only one cause on each line.						Approximate Interv Between Onset ar
Y	/Medical :aminer	a (l	Immediate Cause (Final disease a. Complications of chi	ronic drug u	se				Death
			or condition resulting in death) Due to (or as a consequence of): b.						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			(C) (E) (
	#	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	<u></u>					
	e be executed ysician and burial - transit		d.				<u> </u>		
	sic po	Medical	X UNPENDED X AMENDED #1,23a,27.perME.g8	373, 11/14/0	7 TT			23d. Date of deliv	ery
	687 ertifica ding pl	sician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3	Ectopic pregna	ncy	Month	Day Year
	Box 6876C he death certificate the attending phys hed for use as the b	ıysic	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death	5 Other (Spec	cify)				
	ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate r death. *cetor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the b	by Phy	Part II. Other significant conditions contributing to death but not resulting	ing in the underlying	cause giv	en in Part I.			to the cause of death?
	ords, P.O. w requires that the speen signed by should be detach	ted b					24a. Was a		autopsy findings availa
	cords law requi	Completed				···-	autops perform	prior t med? death	o completion of cause of
3	ion of Vital Records, etching Physician: The law require or: After this certificate has been si the funeral director, page 2 should b		25. Was case referred to medical		26.Place o	f Death (Check o	1 Yes 2	No 1	Yes 2 No
IST NATIVE	Vita nysician this cer	o Be	examiner?			thor.		Residence 6 🗸 Ot	ner: Scene
5	1 Of fing Pl After funeral	T:uc	(Month, Day, Year)	o. Time of Injury	28c. Injury		28d. Describe h	ow injury occurred	
1	Division tal or Attendinated or Attendinated or Attendinated or all Directors. All Directors or the full of the full or the fu	catio	2 Accident Investigation 288 Place of Injury - 4t home	farm, street, factory,		s 2 No	28f. Location (S	treet and Number or	Rural Route Number, C
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	Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or	leath occurred at the r investigation, in my	time, date	e and place, and death occurred a	due to the cause t the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
	To To COI	Me	29b Signature and title of certifier	290	License	number		29d. Date signed (
4			Patu Wonn- Holled	Lib	O.C.M	I.E.		September 25	2007
	8		30. Name and address of person who completed cause of death (Item 23a Patricia Aronica-Pollak MD. Assistant Medical Exa		enn Stre	eet, Baltimor	e, MD 21201	i _	
	St	tate	Loos P. Land Const.	be s.					
	Regis		SEP 2 8 2007 Magne #	epora -					
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Physician	į
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled it by the funeral director, page 2 should be detached for use as the burial-transit

	For State Registrar	Ce	ertificate of E	Death	Reg		31184				
an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death				
ian cal		JEAN ABRI			1	7, 2007	8:15 A M				
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County of Dea					
	118 GRAND DR. 5. Social Security Number 6. Sex 7. As	ge (In yrs. last birthda)	TANEYTOW Ji Under 1 Year	If Under 24 Hrs.	8. Date of Birth	CARROL 9. Bir	thplace (State or Foreign				
ı	215-44-0988 ^{1□M 2} ▼F	61 Yrs.	Months Days	Hours Min.	(Month, Day, You 10/17/1		RYLAND				
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
ō	MD CARROLL		1∏Yes 2□No								
Funeral Director	10e. Street and Number	TANEY	10f. Zip Code		10g	. Citizen of What Co	ountry?				
a D	118 GRAND DR.		217	787	Ü	SA	_				
nuel	11. Marital Status 12. Was Decedent Armed Forces	14. Race - Ame Black, Whit									
	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	Specify: WH	HITE								
Completed by	15. Decedent's Education (Specify only highest grade completed)	b. Kind of Business	/Industry								
Jd m	Elementary/Secondary (0-12) College (1-4or	5+)	ve kind of work done di . DO NOT use retired)		H	OME CARE	E & HOSPICE				
ပ္ပိ	12 17. Father's Name (<i>First, Middle, Last</i>)	Ь	EALTH AT		ne (First, Middle, Ma	iden Surname)					
To Be	Roy Mil	ton Mann	ı	FLOREN	ICE REED	MYERLY					
	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street a	nd Number or Ru	ral Route Number, C	ity or Town, State,	Zip Code)				
	KIMBERLY HALE - DAUGH		O PATAPSO	O RD.,							
	20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State	cemetery, ci	position (Name of rematory or other place			c. Location - City or					
	4 □ Donation 5 □ Other (Specify) 21. Signatur A Hugera/ Service Licensee		CO CEMETE: 22. Name and Address			ATAPSCO,	HOME, P.A.				
	127		254 E. MA								
	23a. Part1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each	d the death. Do not e	enter the mode of dying	, such as cardiac	or respiratory arrest	1	Approximate Interval Between				
	Immediate Cause (Final disease or condition	etcet 5	The Great	COO C	ANCEN		Onset and Death				
ı	resulting in death) Due to (or as										
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mi	Sequentially list conditions, if any, reading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events										
Completed by Physician/Medical Examiner	resulting in death) Last Due to (or as										
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/Me	IF FEMALE: 23c. If yes, outcome	23d. Date of de	livery								
iciar	1 Dves 20 No 4 Pregnant a		B□Ectopic pregnancy □ Other (specify)			Month	Day Year				
hys	9 □ Unknown										
by F	Part II. Other significant conditions contributing to death Dec Vew Hyor		underlying cause give	n in Part I.	23e. Did toba		o the cause of death? Probably 4 ☐ Unknown				
eted	100 July 30101	VV 30373				1					
dm					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of				
	25. Was case referred to medical			26. Place of Dea	th (Check only one)	No 1 ☐ Ye	s 2□No				
To Be	examiner? 1 Yes No Hospital: 1 Inpat	ient 2 ☐ ER/Outpati	ient 3 DOA Othe			ce 6 🗆 Other (Spe	ecify)				
	27. Manne of Death 1 Natural 5 □ Pending (Month, D.		/ Work		28d. Describe how	injury occurred					
cati	✓ Accident investigation 3 Suicide 6 Could not be 28e Place of in	jury - At home, farm, s		′es 2□No	28f Location (Stre	et and Number or E	Rural Route Number,				
ertif	4 Homicide determined building,	(Specify)	,,,		City or Town,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
27. Manny of Death Natural Natur											
Med	29b. Signature and title of certifier	iaieu.	29c. License	number	290	. Date signed (Mon	th, Day, Year)				
	•		D63	231		9/28/0	7				
	30; Name and address term who completed cause of	death (Item 23a) (Type			4						
	YOUSUF GATTER 5550U 31. Date filed (Month, Bay, Year) 62 Regis	th Ceut	er Street	W6StM	juster Mi	1 0115(
ate rar	SFP 2. 8 2007	K A	di'								
	SELS O COM	~ /									

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Physici /Medi		1. Decedent's Name (First, Middle, Last) BETH	Cei	APPLE	2. Date of Dea Month 5 co fember	Day Year 25 2607	3. Time of Death 6:55 P M
Examir Funeral Director	ier	219-70-6313 1 1 M 2X F 5	yrs. last birthday) Yrs.	4b. City, Town, or Location of Death Baltimerc If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	4c. County of Death N/ N/ (Year) 9. Birth County (August 1954)	
e Maryland a-f show tified at	ctor		. City, Town or Lo				10d. Inside City Limits 1 X Yes 2 □ No
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. to file m 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 3708 CLARKS LANE 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 Moo		10f. Zip Code 21215 Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerly		14. Race - Amer Black, White	ISA ican Indian, s, etc.
21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exami	Completed by	3 Widowed 4 Divorced 1f Yes, Give Year or Dates: 1 5. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece	1 Yes 2 No Specify: dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/I	•
Maryland 21 td 2 should be filed wi th and Mental Hygier 77 is marked other the traumatic event, the	To Be Con	17. Father's Name (First, Middle, Last) MELVIN		ONEY RAE		Maiden Surname)	N HOME PHILLIPS
ore, Mary is 1 and 2 sho of Health and Item 27 is m other traum		Total Modern of Disposition	3708	ng Address (Street and Number or Ru B CLARKS LANE, BAI sistion (Name of matory or other place)			. ,
Baltimore, permit. Pages 1 a Department of Hee Important: If Item any injury or othe once.		1	OHEB SHA	ALOM CONG. 09/20 2. Name and Address of Facility So	OL LEVIN	BALTIMORE, SON & BROS.	, INC.
Physician		23a. Part1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.	death. Do not ent				MD 21208 Approximate Interval Between Onset and Death
filicate be executed many g physician and as the burial-transit	ical Examiner	Sequentially list conditions, frame label limits and label limits and label limits and label limits and label label limits and label label limits and label	sequence of): ethological factors and sequence of):	Arrhythmia imbalanca e Renal Failura			lday byrs
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf production in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Ye <i>a</i> r
Cords, P.O. w requires that the been signed by the should be detache	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in Part I.		bacco use contribute to	
	e Completed	25. Was case referred to medical		26 Place of Dece	24a. Was a autop perfor 1 Yes	sy prior to death? 2 ☑ No 1 ☐ Yes	topsy findings available completion of cause of 2 □ No
Jing Affe fune	Certification: To B	examiner? 1	At home, farm, str	nt 3 □ DOA Other: 4 □ Nursing H f	ome 5 ☐ Resid 28d. Describe h	ence 6 Other (Specow injury occurred	
DIVISION To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the ourred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier M. 30. Name and address of person who completed cause of death		29c. License number $\Delta 59062$ Print) Baltimore M		29d. Date signed (Monti	
Sta Registi		Chad Hansen, MA 2401 W 31. Date filed (Month, Day, Year) SEP 2 8 2007 SEP 2 8 2007	Belvedere	Baltimore M	A 2121	5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE of Maryland Tepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elizabeth Burkhart September 27, 6:20 P M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director 234-38-0308 March 6,1927 80 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4217 Penn Avenue Funeral U. S. A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Cashier</u> Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Darrell Prunty 2 Elizabeth Ellen Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 McCormick St., Bel Air, Maryland 21014 Pamela Burkhart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 10/01/ 2007 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer 125 months /Medical Due to (or s consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58302 September 27 2007

State Registrar

7

DHMH 17 Rev 1/2001

6701 N. Charles ST Parson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

ATRON COANING

SEP 2 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Althra BOPP α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Baltin N/A -O.CE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 😿 F 216 16 6331 Maryland 29. 1924 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 106 - 3rd Avenue 21225 U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra once. Ronald Bobby / Husband 106 - 3rd Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔽 Cremation 3 Removal from State 9/24/2007 Baltimore, Maryland To ☐ Other (Specify) Bavview Crematory 4 □ Donation 22. Name and Address of Facility $\mbox{Gonce Funeral Service, } \mbox{P.A.}$ eral Service Lice Ritchie Highway Baltimore, Maryland 21225 4001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardia \sim 0 \sim /Medical s a consequence of): Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autonsy 25. Was case referred to medical examine? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 | Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

be executed burial-trar Division or Vital Records, P.O. Box 68760, requires that the death certificate the attending p the signed by t has certificate this After 1 Hospital or Attending the Funeral Director; After managed the funeral Director; After managed the funeral forms of the funeral forms of the form

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

28a-f show aţ

"natural", or items 23a or 28a-f st edical Examiner must be notified

n and Mental Hygiene.

Pages 1 and 2 should be in nent of Health and Mental

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Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

29b. Signature and title of certifie

Medical

State

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

29c. License number

Edna R. Hill, MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street Hanover Baltimore

31. Date filed (Month, Day, Year) SEP 28 2007 . Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:50 A M Vivian Arbutus Bennett September 22, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 M 2 XF Hours 82 Jan 8, West Virginia Director 234-36-1076 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 TxYes 2 □ No Director Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a Funeral 9100 Huntington Court Apt X-2 U.S.A. 20707 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur. any injury or other traumatic event, the Medhal E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Charles Elswick Violet Kidd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Dumain 6553 Palisades Dr. Centreville, Virginia 20121 /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. National Mem.Pk. Sept 25, 07 Laurel, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the dillease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear if jury. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ODSIS /Medical Due to (or as a consequence of): **Examiner** THINGS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence office Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending phase as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9□ Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes 2⊠ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 2 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inc SOUNGE CMO 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar SEP

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GEORGE CLARK BLANCH, JR. 23 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1**X**OXM 2 □ F 219-80-8012 46 Dec. 15, 1960 Washington, DC Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8312 Cowan Avenue 20720 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1XXNever Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White 3 □Widowed 4 □Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker llth Ø Carter Worx 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Clark Blanch, Sr. Wanda Jean Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Herbert/Sister 8312 Cowan Avenue, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 19/27/2007 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one dauge on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Floute Henaho Due to (or as a consequence 1) Sequentially list conditions, if any, leading to immediate cause. Enter the confider Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√ No 24a. Was an autopsy performed? res 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked any injury or contract. Physician /Medical **Examiner** The law requires that the death certificate be executed

Examiner

Physician/Medical

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Certification:

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Funeral

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Completed by Funeral

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filed within 72 hours after death with the Maryland

use as the burial-transit and signed by the attending physician d be detached for use as the burial peen has after death.

Director: After this certificate filled in by the

Division or Vital Records, P.O. Box 68760

the Hospital or Attending Physician:

within 24 hours a To the Funeral D

6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and the of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death them 23a) (Type, Print) Name and address of person who completed cause of death them 23a) (Type, Print) Rocie no 2e71) 31. Date filed (MSntr. Day Year)

State Registrar 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 State Registrar Amend 14,18, perFH, g871, 9/28/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 M **BAUMER Physician** SAMUEL 25 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/23/1913 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F 93 Months NY Director 496-12-8294 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 22. any injury or other traumatic event, the Mariana. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Directo BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21208 7920 SCOTTS LEVEL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: White U.S.A. 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OPTOMETRY OPTOMETRIST 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **SLUTSKI** CASSIE Slutsky BAUMER YECHEZKEL ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3101 SZOLD DRIVE - BALTIMORE, MD 21208 <u> JOSHUA ADLER / NEPHEW</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/26/2007 FERNDALE, MI. BETH TFILOH 22. Name and Address of Facility SOL LEVINSON & BROS., uneral Service Lic-8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 wo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INV disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Due to (or as a cons, uence of Examine attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 → Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/O မ 1 Yes cify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate this Director: After within 24 hours a To the Funeral I

			26	. Place of Dea	th (Cl	heck only one)	
utpatient	3 🗆 [OOA	Other:	4 ☐ Nursing H	ome	5 Residence	6 □Other (Spe
Time of Injury		28c.	Injury at Work?		28d.	Describe how inj	ury occurred

28a. Date of Injury (Month, Day Year) M 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

Registrar's Signature

31. Date filed (Month, Day, Year) SEP 2

5 Pending investigation

6 Could not be

determined

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

State Registrar

Certification:

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Division or Vital Records, P.O. Box 68760,

Examiner law requires that the death certificate be executed burial-tran attending p ed by the detached page 2 cate Hospital or Attending Physician: the Funeral Director: A To the F

Physician

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 1 once.

Physician /Medical

/Medical

shock, or heart failure. List o	only one cause on each line.	or respiratory arrest,	Interval Between
Immediate Cause (Final disease or condition resulting in death)	a ACUTE MYOCARTIAL		Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):		
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		
resulting in death) Last	Due to (or as a consequence of):		
2	d		
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No			
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy	23d. Date of deliv	(en)
in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	Month	Dav Year
1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 ☐ Other (specify)		54,
9 Unknown	SECTION		
	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
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144 100	+44 ROID	performed? death? 1□ Yes 2□ No 1□ Yes	2□ No
25. Was case referred to medical			2010
examiner?	Hospital:	th (Check only one)	
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27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred	
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3 Suicide 6 Could no	t he		
4 ☐ Homicide determin	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Run City or Town, State)	al Route Number,
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29a, Certifier 1 Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the cause (s) and manner as	etatod
(Check only 2 Medical E	xaminer: On the basis of examination and/or investigation, in my opinion, death occu	rred at the time, date and place, and due	to the cause(s)
Orie)	and manner stated.		
29b. Signature and the of certifier	29c, License number	29d. Date signed (Month,	, Day, Year)
	a Maria	7775	0 / 420.
CARLES N. RA	TAUNGTING SEND DISTEL	SEPTEMBLE	26,2007
30. Name and address of person w	ho completed cause of death (Item 23a) (Type, Print)		

State Registrar 31. Date filed (Month, Day, Year)

Physician /Medical Examiner

attending physician and for use as the burial-tra

signed by the a

Be

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Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Saltimore, Maryland 21215-0036

h and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

r 28a-f show notified at

24a. Was an autopsy 1∐ Yes 2

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d Describe how injury occurred

29a, Certifie (Check only

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hospital:

29c. License number 30263

2115

29d. Date signed (Month, Day, Year)

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State

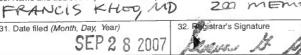
Registrar

within 24 hours after death

To the Funeral Director: of completely filled in by the f

31. Date filed (Month, Day, Year)

SEP 28 2007



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOD, MD 200 MEMOR(AL AVE. WESTMINSTER)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Departm		ental Hygie	ne	
			1 - State Registrar Certific	ate of Death	Reg.	No.2 1 1 7	31193
н	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medi		Kenneth Crockett				12:30 a ^M
	Examir	er		City, Town, or Location of Death		4c. County of Death	
				altimore			
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	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Ö	3914 6th Street	21225	1.09	U.S.A.	
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Form of Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decede	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American	Indian,
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و			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory	or other place)		. Location - City or Town	i, State
ţ	t. Partmer		4□Donation 5□Other (Specify) Bayview Cre	matory 10/1/0	07 Ba	ltimore, Md	•
Baltimore,	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility Gonce	e Funeral	Service P.	Α.
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		c 30	23a. Párt1, Enter the disease or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.	node of dying, such as cardiac or	respiratory arrest,	In	pproximate terval Between nset and Death
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	/Medical Examiner		Due to m/s a consequence of):	1. 2.1			2011
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	requires that the death certi een signed by the attending hould be detached for use a	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	ig cause given in Part I.	23e. Did tobacc	co use contribute to the o	cause of death?
Ď	w require been sk should b	ed	Chronic Renal Failure		1 ☐ Yes	2 No 3 Probabl	ly 4 Zlunknown
သို	> 470	Completed			24a. Was an	24b. Were autopsy	findings available
æ	0 <u>c</u> 0	mo			autopsy performed 1□ Yes 2 🛣	death?	letion of cause of ☐ No
ţa	ilcian: Th certificate ector, pag	Be C	25. Was case referred to medical	26. Place of Death (NO TLITES 2L	7 140
or Vital Records,	Attending Physician: or death. fector: After this certific. by the funeral director,	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Other		e 6 □Other (Specify)	
0	ding Ph	Ë	27. Manner Death 28a. Date of Injury 28b. Time of Injury Injury		d. Describe how in		
<u>Ö</u>	Attending r death. ector: After by the fune	atio	2 ☐ Accident investigation M	1 Yes 2 No			
Division	er de recto	ti ji	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, face building, etc. (Specify)	tory, office 28	f. Location (Street City or Town, St	t and Number or Rural Retate)	oute Number,
Õ	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	(
1	Hospital		29a. Certifier (Check only and Check on Check only and Check only	red at the time, date and place, an	nd due to the cause	e(s) and manner as state	ed.
0	the H	Medical	and manner stated.				
	vith To	2	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day	y, Year)
)			· Cowell tarts	DU1437		41.20,0	w/
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00 1	11 0	1. (1	2 12 12 1
(Colvin (arter, mi), 4710	rennington	HUE: 1.	39/10/14/	1. 2126
6	Sta Registr		29b. Signature and title of certifier Colored Cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) SEP 2 8 7007	/			
	negistr	:II	SFP 2 8 2007 May A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Sitem 21 per fth 8871 9-28-07 wt and Mental Hygiene

		1 - For State Registrar 1. Decedent's Name (First, Middl.		-	Certificate of	Death		No.2007	3 9 4 3. Time of Death
Physi /Med Exam	dical	William 4a. Facility Name (If not institution	n, give street and number)	rey		r Location of Death	Month eptember	18, 200 4c. County of De	7 3:40 a. M
Funera Directo		7932 Barnhill 5. Social Security Number 213–26–1704 Usual Residence of Decedent		6 (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Young 1905)		irthplace (State or Foreign Country)
he Maryland :8a-f show otified at	ector	MD 10b. County Anne	Arunde1	10c. City, Town	ern				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Q Z1Z15-UU36 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	Funeral Director	7932 Barnhill 11, Marital Status	Circle 12. Was Decedent E Armed Forces?	ever in U.S.	10f. Zip Code 21144 13. Was Decedent of H If Yes, specify Cuba			10g. Citizen of What Country? USA No- 14. Race - American Indian,	
-UUJO 2 hours after atural", or it cal Examine	ted by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes, Give Year or Dates:	16a. D	1 ☐ Yes 2X No	Specify:		Black, Wh	hite
1 21215-0036 iled within 72 hours af tyglene. ther than "natural", or nt, the Medical Examl	Completed by	(Specify only higher Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle,	College (1-4or 5+) Supe		Give kind of work done of the life. DO NOT use retired ervisor	e kind of work done during most of working DO NOT use retired) TVISOR		Manufact	ure
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	To Be	William Edward 19a. Informant's Name/Relations	l Cordrey, Sr		Mailing Address (Street	18. Mother's Name (F Mary Tru and Number or Rural F	iitt	<u> </u>	Zip Code)
		Nancy Cordrey 20a. Method of Disposition 1 Burial 2 Cremation	3 ☐Removal from State	793 20b. Place of E cemetery,	2 Barnhill Disposition (Name of crematory or other place	Circle, Se	vern, M	aryland 2 c. Location - City of	21144 or Town, State
Baltimore, permit. Pages 1 a Department of Her Important: If item any Injury or othe		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service Matthew				ery 09/21/ ss of Facility Gonc nie Highway	e Funer	al Servi	
Physiciar /Medica Examine		Immediate Cause (Final disease or condition resulting in death)	a. Emphys Due to (or as a	e. ena consequence of osclerot	ic Cardiova				Approximate Interval Between Onset and Death Yrs Yrs
rificate be executed applysician and as the burial-transit	edical Examiner	Sequentially list conditions, if any leading to final data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Hyperte	consequence of):				Yrs.
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	, 1		23d. Date of do	elivery Day Year
he law requires that e has been signed by age 2 should be deta	þ	Part II. Other significant conditi	ons contributing to death bu	t not resulting in t	he underlying cause give	en in Part I.			to the cause of death? Probably
VICAL DEC Iclan: The law certificate has b rector, page 2 st	Completed	25. Was case referred to medica				26. Place of Death (C		prior to	
tending Physical Cr. After this the funeral direct	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day) gation not be	Year) Inji ry - At home, farm	ne of 28c. Injury	er: 4 Nursing Home y at 28d k? Yes 2 No	5 X Residence	injury occurred	ecify) Rural Route Number,
To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by	Medical Ce	one)	ng Physician: To the best o Examiner: On the basis of and manner stat	f my knowledge, examination and/	death occurred at the tin or investigation, in my o	me, date and place, and place, and pinion, death occurred	due to the caus at the time, date	se(s) and manner a and place, and di	as stated. ue to the cause(s)
Tot Tot	M	29b. Signature and title of certifie	M	MI	29c. License D147		29d.	Date signed (Mor	oth, Day, Year)
10+1 s	tate	30. Name and address of person C. Thomas Folko 31. Date filed (Month, Day, Year)	emer,MD., 423	1 Posta	Court #10	2, Pasadena	a, MD 21	122	
Regis	trar	SEP 2	8 2007	w K	Gode				

DHMH 17 Rev 1/2001

ORIGINAL

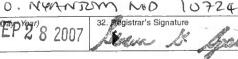
15

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

31. Date filed (Month Charp Year) State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



21544

COZUMAIA MAD

1)36974

	,			artment of Health and N	Reg	ene a. No. 2007	31196
4	Physic		1. Decedent's Name (First, Middle, Last) Mary Dolores Collins		2. Date of Death Month Sept	Day 2007	3. Time of Death
Q.	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jehr	4c. County of Death	7:00P M
			608 Valley Lane	Towson		Baltimore	
	Funeral Director		5. Social Security Number 217-46-2150 Cusual Residence of Decedent 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday 106 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp Cour Mary	place (State or Foreign htry) land
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	ctor	10a. State MD Baltimore 10c. City, Town or L	ocation		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
		Funeral Director	10e. Street and Number 608 Valley Lane	10f. Zip Code 212 86		g. Citizen of What Cour	ntry?
980	ours after dea ral", or items Examiner mu	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	ecify Yes or No- Rican, etc.)	s or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	within 72 housene.	Completed by	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	iwn Home	dustry
Maryland 2	ev d atal	To Be C	17. Father's Name (First, Middle, Last) Francis Zeller		First, Middle, Ma	niden Surname)	
Mary	and sm			ng Address (Street and Number or Run			Code)
	1 an Feal		20a, Method of Disposition 20b, Place of Disp	osition (Name of	n, MD 212	86 Oc. Location - City or To	wn State
<u>0</u>	Pages nent of I int: If ite			matory or other place) Valley mem. 9/29/		imonium, Ma	
Baltimore,	permit. Pages. Department of the Important: If ite any injury or or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Luck Towson Funeral	uson. Mar Home, Ii	Yland ₁ 2120(t York Rd.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			^	Approximate Interval Between Onset and Death
8760, 🗸	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence of course consequence of course a consequence of course cours				
P.O. Box 687	death certific e attending p d for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
	The law requires that the de tte has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the u			cco use contribute to the	e cause of death?
al Reco	: The law requ cate has been , page 2 should	Completed			24a. Was an autopsy performe	d? prior to cor	psy findings available npletion of cause of
Vit;	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inputient 2 ☐ EB/Outputiel	Othor	(Check only one)		<i>y</i>
Division or Vital Records,	Attending r death. ector: Afte by the fune	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 PR/Outpatiet 2 ER/Outpatiet 2 ER/Outpatiet 2 ER/Outpatiet 2 ER/Outpatiet 2 ER/Outpatiet 2 Ba. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of In	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	et and Number or Rura	
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Ir	Medical Ce	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, deat 2 □ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as st e and place, and due to	ated, the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier William E Rancall, J W	29c. License number	29d.	Date signed (Month, 1972)	Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, WILLIAM E. RANDALLI MD, 1205	Print) YURK RD , #33	Luth		nd 21097
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, William E. RANDALLI MD. 1205 31. Date filed (Month, Day, Year) SEP 2 8 2007	les.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sepkmber 33, 3007 **Physician** 3:30 RM /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner ledar Mills hoad handal Saltimore Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director 946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Director Baltimore handallstain 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? SA r than "natural", or items 23a the Medical Examiner must b Polar Mills Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X/es 2 No If Kes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 No Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced blach Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumest. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha ('Oles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ayce N. Coles 1021 Codor mills My Thondall Han MD 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 10.01.2007 Owings mills MD 22. Name and Address of Facility Voughn C. Everne Juneau Service 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rd Mondellstam no 21133 Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE END RENAL FAILURE /Medical Due to (or as a consequence of): Examiner ARTEMOSCLEROTIC VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed DIABETES MELLITUS TYPE 2 burial-trar and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by ARTERY CORONARY certificate has been si ector, page 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Dir completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) vithin 24 29b. Signature and title of bertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pajistrar's Signature

RAYNOLD DEPESTIVE
31. Date filed (Month, Par Fear)
SEP 2 8 2007

8

D27157

3100 LORD BALTIMORE DR. #110 BALTIMORE, MD 21244

SELTEMBER, 26,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07530 State of Maryland / Department of Health and Mental Hygiene Stanley Clarkson 2007 31198 1- For State Amend #19a Per Inf G872-10/01/09/Delath Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 25, 2007 1620 hrs Clarkson Stanley Ncal Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore** 101 W. Fayette Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY g. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Min 02/10/1954 Country) PA 209-44-1211 Director 53 1 X M 2 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State any 1 Yes 2 X No Sicklerville Camden NJ 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 08081 15 Sassafras Drive 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married Yes Black Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Widowed 4 "natural" the Medical Examiner <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Communications Program Specialist MD 21215-0036 Compl other t 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked o Mary Clarkson Marion Be ges 1 and 2 should by t of Health and Ment 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name (Palationship (Type, Print.) fe item 27 is 1 15 Sassafras Dr., Sicklerville, NJ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, crematory or other place)
Camden Co. Crematory or other 2 X Cremation 3 Removal from State 09/29/07 Atco, NJ permit. Pages Department of Important: I Donation 5 Other Specify: 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility . Name and Address of Facility Leonard J. Ruck 5305 Harford Rd., Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line Death **Medical** Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Records, r.o. ..o..

The law requires that the death certificate be executed. Due to (or as a consequence of): events resulting in death) Last Physician/Medical XUNPENDED AMENDED, 7, perME, g872. burial 10/4/07 TI Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy ing phys Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown has been signed by the 2 should be detached 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 🗸 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy . death? performed? Yes 2 V No 2 No certificate h 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medica Be Other₄ Hospital: 1 examiner? Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 26, 2007 O.C.M.E. Doma nu monti, M.D. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

31. Date filed (Month, Day, Year) SEP 2 8 200

OCME

Donna M. Vincenti, MD Assistant Medical Examiner Z. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Janet Ann Cassidv 2:45 PM September 25, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Holly Hill Manor Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 84 February 25,1923 Maryland 220-14-7725 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Easton Director Maryland Talbot 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 United States 258 Brookwood Ave., Apt. D Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify. Specify: white Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) homemaker own home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Back Elmer C. Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21204 945 Fairmount Ave. Towson, MD Debbie Hughes/niece Baltimore, Department of Heal Important: If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardSep. 28,2007 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John O, Mitchell IV, Funeral Services of Dulaney Valley, P.A. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dreum 2119 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a Was an autopsy performed? Yes 2 No 1□ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours an Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MD 21204 York 32. Registrar's Signature State

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Registrar

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K .	Sta Registr		TAR / Q _ M / 31. Date filed (Mooth, Day, Year) SEP 2 8 20	107 Registrar's	Signature	W.				

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23a or the Medical Examiner must be

Baltimore, Maryland 21215-0036

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Director

Funeral

Completed

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The law requires that the death certificate be executed

Examiner Physician/Medical ģ Be Completed page 2 certificate completely filled in by the funeral director, Certification: To this

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENT 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5♥ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

200 47625

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and addr. ss of person who completed cause of death (Item 23a) (Type, Print)

omalley, us 7600 OSWA DVI'VE, SVIFE 311. TOWSON, MD 2120H

State Registrar

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31. Date filed (Month.

Registrar
DHMH 17 Rev 1/2001

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3001 Hospital Drive, Cheverly, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Salvador Sylvester,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:55PM M September 24,2007 Daniels Theresa Helen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Genesis of Waldorf Waldorf 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 X 30,1914 Washington, 93 Director 579**–**18–1021 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is amended other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Waldorf Director Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20602 4140 Old Washington Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3.☐.Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Investigation Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Judge Francis J. Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10858 Pam Drive Waldorf, Maryland 20603 Robert Daniels (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. Date 29. 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6633 Old Alexandria Ferry Road Clinton, MD 20735 moc257 Approximate Interval Between Onset and Death 23a f a.f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DISEADE Immediate Cause (Final le Em **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Division or Vital Records, P.O. Box 68760,な Due to (or as a consequence of): Physician/Medical the as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ow 30. Name and address of person who completed cause of speath (Item 23a) (Type, Print) 102 PAULMELLONG , WALDORF MD20602 6 SHVINKYMAR ATTI 31. Date filed (Month, Day, Year) SEP 2 8 2007 Registrar's Signature State Registrar

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Division or Vital Records, P.O. Box 68760, After this certificate has been signed by ' funeral director, page 2 should be detach after death 24 hours a within 24

24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Cromwell M.D., 831 University Blvd. E, Silver Spring , MD 31. Date filed (Month, Day, Year) SEP 2 8 2007

5 Pending investigation

6 ☐ Could not be

determined

32 Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar

Medical

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

1 Natural

07-07460	
Elaine Ellis	

laine Ellis	Certificate of Death	20
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	
Wedical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Maryland General Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. SEPT 15.195i Country MARIL	AND
*	Usual Residence of Decedent	imits
d te.	100. State	
tith the Maryland 23a or 28a-f she notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the 23a or notific	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	
r death with or items 23 must be no	1 Never Married 2 Married 2 Married 2 Married 1 Yes 2 No White, etc. White, etc.	
ural", o	3 Wildowed 4 Divorced in res, directed of pates. 165 December 17 Tes 2 No specify. 166 December 17 Tes 2 No specify. 166 December 166 Kind of Business/Industry.	
5-0036 ed within 72 hour lygene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	100
15-0036 Thed within 7 Hygiene. d other than	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	Œ
21215-0036 ald be filed within 7/ Mental Hygiene. marked other than e event, the Medical	JOHN EVANS MABLE GREEN	
Shoul shoul and N	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIC HELLE ID DATIN (SISTED 1334 GITTINGS AVE. BAITO, MD 212:	39
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traumaninjury	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, place) 20c. Location - City or Town, State crematory or other place)	
	4 Donation 5 Other Specify: MT, ZION CEMETERY 10-01-01 LANSOOWNE, M	0
Baltimo permit. Pag Department Important:	21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR FUNERAL AL AL CONTROL OF THE PROPERTY	OME
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Int	
Medical caminer	Immediate Cause (Final disease or condition resulting in death) Death Death Death Death Due to (or as a consequence of):	-
	Sequentially list conditions, b.	
ed nsit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Gauss (Disease or injury that initiated	
and and transit		
60, ate be execus hysician and e burial - tra	X UNPENDED AMENDED #23a, 27, 28a-f. perMF, g872, 10/11/07, TT 23d, Date of delivery	
ox 6876(eath certificate eath certificate eath certificate eath certificate or attending phy for use as the bracinian/Ma	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
. Box 68760, the death certificate be by the attending physic ched for use as the bur Dhyrsician/Mod	1 Yes 2 No 9 V Unknown	
P.O. Es that the d		
cords, P law requires that has been signs 2 2 should be d	24a. Was an 24b. Were autopsy findings ava	ilable
Records, The law requires ficate has been sig page 2 should be	autopsy prior to completion of cause death? 1 ✓ Yes 2 No 1 ✓ Yes 2 N	
tal Rections: The rector, page	b 25. Was case referred to medical 20. Flace to Learn (Check Unity One)	
of Viling Physic After this luneral din	1 V Yes 2 No Impatient 2 Endoupatient 3 DOA 4 Invising Notice 5 Headered 5 Collection 128a Date of Injury 28b Dime of Injury 28c Injury at Work? 28d Describe how injury occurred	
ion c tending teath. tor: Af the fun	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fnd 9/24/2007 Fnd 9:42 am 1 Yes 2 X No unk	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined determined (Specify) Sidewalk 28e. Place of Injury - At home, farm, street, factory, office building, etc. 128f. Location (Street and Number or Rural Route Number or Town, State) 1407 Druid Hill Ave. Baltimore.	
ie i		110
To the He within 24 To the Fu completely	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	Moling Grassell MD O.C.M.E. September 25, 2007	
X	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra	SEP 2 8 2007	

State Registrar

DHMH 17 Rev 1/2001

6701 N.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAPLES MO

SEP 2 8 2007

31. Date filed (Month, Day, Year)

58303

Charly ST TONSON NO 21204

September 26 2007

Phys /Me Exan

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F	S Regis	tate trar
DHMH 17	Rev 1	/2001

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		1 - State Registrar Ame	end #20b,pe	erFH,G872, 10,					R	eg. No 2	07	21208
icia dic		1. Decedent's Name		<i>'</i>					2. Date of Dea Month Septemb	er 25,	Year 2007	3:12 p M
nine			_	e street and number)			4b. City, Town, o	r Location of Death		4c. County		
		-		1 Hospital			Olney If Under 1 Year	T If I Index Od Line	To D : "(5)		gome:	
al or		5. Social Security N 214-42-25 Usual Residence of	513	DM SDE	e (In yrs. Ia 2	as <i>t birthday)</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV • 29	Year) 1944	9. Birthp Coun Ma	lace (State or Foreign htry) ryland
	o,	10a. State Maryland	10b. County Howard			Town or Lo	ocation				1	0d. Inside City Limits
	rect	10e. Street and Nur				10101	10f. Zip Code		1	Og. Citizen of \		
		10048 Sup	perior Av	enue			20723			U.S.A.		
	by Funeral Director	11. Marital Status	ied 2/€XMarried	12. Was Decedent B Armed Forces? 1XXYes 2 No		3. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Prican, etc.)		ce - Americ ck, White, V: Wh	
7.0	Completed by		15. Decedent's Ed	ducation	Ţ	16a. Dece	dent's Usual Occup	oation during most of work d)	king [16b. Kind of B		
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	ပ္ပ	17. Father's Name ((First Middle Last)		Етес	ELICIAN	18. Mother's Nam				OI MD
	To Be	James Les						Ruby Do	. ,	The state of the s		
		19a. Informant's Na Agnes Fay		<i>Type. Print)</i> Furr/spous	e	1	-	and Number or Rui r Avenue				Code) 20723
		20a. Method of Disp	oosition		20b. Pl	ace of Dispo	osition (Name of matory or other place	>		20c. Location -		wn, State
		4 □ Donation	5 ☐ Other (Specif			t Arun	del Crema	atory 11/			on, M	aryland
ouce		21. Signature of Fu	Inoral Gervice Licer		0770			ss of Facility Funeral tt Avenue			land	20707
	sal Examiner											Interval Between Onset and Death
	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown d. 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									te of delive	ery Day Year
Ι.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									ne cause of death? ably 4 ∐Unknown	
	Completed	24a. Was an autopsy prior to or death? 1									prior to cor death?	psy findings available npletion of cause of 2 No
	Be (25. Was case referrexaminer?	red to medical					26. Place of Deat	th (Check only on	ne)		
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1	10 I	27. Manner of Death 1 Natural	n 5 □ Pending investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred			
	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At hor c. (Specify,	me, farm, str	reet, factory, office		28f. Location (St City or Town		er or Rura	l Route Number,
	Medical Ce	29a. Certifier (Check only one) 1										
1	Me	29b. Signature and	title of certifier	frespi	face	204	29c. Licens	05-941	1	9d. Date signe	. /	
		Or RX	KHMA	completed cause of de	eath (Item 3/0/	23a) (Type,	Print)	lip Dr	Olacy	all) De	0832
itat stra		31. Date filed (Mont	th, Day, Year) EP 2 8 200	2. Registra	ar's Signat	23a) (Type,	de)	0	8			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ELIZABETH MARIE FOSTER SEPTEMBER 25, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALITMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3/30/1914 Birthplace (State or Foreign Country) 1 M 2 TF 212-10-5337 93 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3026 THIRD AVENUE 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify. 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE BANK TELLER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILTON ADAM HECKWOLF ANNA M. BOSSE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 WALKER AVENUE BALTIMORE, MD 21212 MARGARET ANN FEUSTLE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation MOST HOLY REDEEMER CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2007 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licensee Wen 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoc, or heart failure. ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL BLEED Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Linter Unionlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d Date of delivery

Physician /Medical Examiner

permit. Pages 1 and 2 should be fi Department of Health and Mental F Important: If Item 27 Is marked oit any Injury or other traumatte even

Physician

/Medical

Director

Funeral

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Completed

Be

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MD

Examiner

Funeral

Director

ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division or Vital

signed by the

Examine Physician/Medical Completed by To Be

IF FEMALE

29b. Signature and title of certifier

31. Date filed (Month,

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1	Month Day Year						
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob	es 2 No 3 Probably 4 Unknown						
	24a. Was ar autops perform 1 Yes 2	y prior to completion of cause of						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	nce 6XIOther (Specify) HOSPICE						
27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? M 1 □ Yes 2 □ No	w injury occurred						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town)	reet and Number or Rural Route Number, , State)						
	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the canner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dand manner stated.							

043725

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

9/26/07

State Registrar

DHMH 17 Rev 1/2001

5

2300 DULANEY VALLEY RD.

32. Restrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month TAXINE GILFORD HAYNIE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lutheran Nursing 170Me
1 & Sex 7. Age (In yrs. last birthday) BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)
VIRGINIA **Funeral** Months Days 1 M 2 M Hours 212-22-3495 Director 19,1920 AUGUST Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1X Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 3104 THORNFIELD ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 7 is marked other than "natural", or i traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMES 12TH GRADE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HAYNIK HARVEY ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERTS (DAUGHTE) 3104 THORNFIELD Department of Health Important: If Item 27 any Injury or other tr 27 RD, BALTIMORE, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEM. 09-29-2007 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avanua 21217 21. Signature of Funeral Service Licenses H. Brown, Jr. Luneral Home Baltimore MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINSONS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f 9□Unknown 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, þ IABETES 1 Tyes 2 □ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate Division or Vital 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 llami 30. Name and address of person who completed cause of death (item 23a) (Type, Print) AVE, SUITE 203, BALD MI 21209 2835 TASNEEM SMITH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 8 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Benjamin Gansallo 2007 3121 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 20, 2007 0928 hrs **Medical Examiner** Benjamin Adekunle Gansallo c. County of Death 4h, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Columbia Howard Howard County General Hospital If Under 1 Year I If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. Director Country) Nigeria 1 XM 2 F March 2,1974 219-33-3276 33 Vrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No MD Howard Columbia with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Nigeria 12030 Little Patuxent Parkway 21044 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried Yes Yes 2 X No specify: Black If Yes, Give Year Specify: hours after 3 Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 72 marked other than 'c event, the Medical MD 21215-0036 3 Operations Manager Allied Barton permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Gansallo Florence O. Ajewole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Olawunmi O. Gansallo 12030 Little Patuxent Pkwy Columbia. (Wife) MD 21044 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) t: If i 1 X Burial 2 Cremation 3 Removal from State Columbia Memorial Pk. 9-29-2007 Clarksville, MD Donation 5 Other Specify: 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee MOIOSD 5555 Twin Knolls Road Columbia, MD 21045 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 27, perME, g872, 10/1/07 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death Pregnant at time of death 5 Other (Specify) signed by the atte be detached for u 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No To the Funeral Director: completely filled in by the Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME O.C.M.E. September 21, 2007 Jn. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State D 2 Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 17 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 545 PM 120TH HOPPE 9 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner If Under 24 Hrs.

Yours | Min.

Month, Day, Year) Social Security Number romwe 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months Days Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 27s ~ ~ ~ any injury or other traumatic event. Ite Maryland any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No by Funeral Director Timore 10e. Street and Number 10g. Citizen of What Country? 21 USA 9 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mever Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zwode) 3936 -Son MD 2108 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Teremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel + Cremator 22 Name and Address of Facility 21. Signature of Funeral Service Licensee 3 Newpor Itill mo 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock **Physician** /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as consequence of) Examiner physician and sthe bunal-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
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To the Funeral I

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier クタチアノチ 2710 EMGE CIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fro my FERMANAO

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 2 8 2007

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 7 0 7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2007 6:15AM VICTOR THEODORE HIPPLE, JR. SEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MANOR CARE NURSING FACILITY ROSSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 - 28 - 1941 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**⅓**M 2□F Months 219-36-1707 65 PENNSYLVANIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b Count 10d. Inside City Limits MD BALTIMORE Director ROSEDALE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8803 PENNSBURY PLACE 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 □ No If Yes, Give Year or Dates TEINAM 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No <u>م</u> Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 STATION MASTER PENN STATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VICTOR THEODORE HIPPLE, SR. AMY Ε. (PATTERSON) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBRA TORRES/DAUGHTER 214 BRANCH BROOK CT BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OF FAITH C 9-28-2007 BALTIMORE, MD

22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) **CARDENS** 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARYNGEAL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NEUMONIA 2 No 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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P.O. ed by the a detached f signed by t Division or Vital Records, neec page 2 certificate this funeral After within 24 hours after deatn.

To the Funeral Director: Aft ō To the

Physician

/Medical

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Funeral

Director

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ns 23a or 7

7 is marked other than "natural", or items traumatic event, the Medical Examiner mu

Department of Important: If it any Injury or o once.

Physician

/Medical

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Examiner

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Box 68760,

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certif

Pages 1 and 2 should be filed within 72 hours after in not of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or item

3altimore, Maryland 21215-0036

death

State Registrar BAEIL

d cause of death (Item 23a) (Type, Print)

201,

29c. License number

000605-60

29d. Date signed (Month, Day, Year)

RIVER NECK RO # 109, BALTIMURE, MA

SEPTEMBER 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year ARLETTA ROSE HESS /Medical september 22 2007 11: 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death litizen's Havre lussing If Under 24 Hrs. 8. Date of (Month, Home 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 □ **X** Director 215-28-2447 76 11, 1930 Dec. Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f sh notifled Director 1 ☐ Yes 2 ☐ No Maryland Harford **Edgewood** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 2425 Green Heart Lane Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 21040 USA ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 □ Divorced "natural" White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta item 27 is marked UNKNOWN Charlotte Russell Zell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Hess / Daughter 2802 Singer Woods Drive, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9-24-07 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Kussell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final ascular Accident Physician un resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit certificate be executed Exami and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No detached the 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate performed 1∐ Yes less Arletta To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mp Winan

State Registrar

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SEP 2 8 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trons of House Grown and 21078

132600

9/2300

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 8 2007

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actient known

. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death. To the 1

Registra

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 2 8 2007

Assistant Medical Examiner Pamela E. Southall, MD

OCME

30. Name and address of person who completed cause of death (Item 23a)

2. Registrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5 perFH G872 10/12/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No D 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Vear 0518 AM 09 Harry Thomas Jones 26 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rosedale If Under 1 Year | If Under 24 Hrs Baltimore FRANKLIN SQUARE HOSPITAL center 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** i. Social Security Number 236–32–0882 Months Days 1⊠M 2□F Hours Min. Director 7/20/1925 West Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Plastic Court 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1947-72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify Specify: White 1949 3 Widowed 4 Divorced "natural". injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Laborer Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Everett Jones Goldie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heatth ar
Important: If item 27 is
any injury or other trau Winoma Jones (Wife) Plastic Court, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Wagurial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. 09/29/2007 Baltimore, Maryland ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21 Sinnature of Funeral Service Lic insee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia Iweck /Medical Due to (or as a consequence of): Examiner Cancer Colan months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 1□ Yes 2 1No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number and title of certific 29b. Signatur 29d. Date signed (Month, Day, Year) D63054 September 26, 2007 person who completed cause of death (Item 23a) (Type, Print) 30. Name and are, Baltimore, Maryland Wajid Cina, MD, 9000 Franklin Square 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 8 2007 Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 25 09 2007 0229 nristine ohason /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 2.01. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Country) 1-68-2670 1 □ M Director Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Drive Apt 301 21215 herle 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. perriit. Pages 1 and 2 should be filled within 72 hours offer Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 No 1 Never Married 2 Married Specify Baltimore, Maryland 21215-0036 Completed by Blach 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public rincipal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be e 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AP+301 Baltimere MO 21715 Partlow amal Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □R 4 □Donation 5 □ Other (Specify) 3 ☐Removal from State 7 (dge 09.27.2007) 22. Name and Address of Facility Vough n.C. Balt imore Green Junnel service 21. Signature of Funeral Service Licensee 8728 hondalista mo Liberter Ulen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Days Sepsis /Medical Due to (or as a consequence of): Examiner Cholangiocarcinoma
Due to (or as a consequence of): Months Sequentially list conditions, if any, leading to immediate cause. Litter or carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a e detached fo 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d q 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 Yes 2 No performed⁴ certificate 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA P this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director; A 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30206 09 26 2007 W 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Charles St., Rm 4004; Baltimore, MD Pearlman, MD Steven Η. N. 31. Date filed (Month, Day, Year) SEP 2 32. gistrar's Signature State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Sep 1 2007 DANN KWEDAR 02:35AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death aenea Howar Colum Hospital %ek 12 M 2**X** F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Months Davs Hours 73 297-32-2432 05/22/1934 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 201 No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6321 Euclid Ave. 21075 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Specify.White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Seagrams 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Townsend Madge Lantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Stultz/Daughter 4850 Carmella Dr., Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 09/25/2007 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Carry L. Kaufinen Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kesninbi Due to (or a a consequence of): hronic 66 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

l Hygiene.

marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event once.

Baltimore, Maryland 21215-0036

the death certificate be executed attending physician and for use as the burial-trar

Box 68760

or Vital Records, P.O.

Physician;

Hospital or Attending

To the

within 24 hours a To the Funeral L

Examine Physician/Medical Completed by page 2 completely filled in by the funeral director, Be Certification: To this after death

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy performed 1☐ Yes

2 NO

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ho

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 29b. Signature and title of certifier MD, FOCE

mac

29c. License number 036845

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mai-Chi haguyen, MD

31. Date filed (Month, Day, Year)

Medical

State Registrar

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26, **Physician** Month Sharon Elizabeth Kitko September 2007 4:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21 Hammock Trail Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M Director 215 54 1367 59 Jan 22**,**1948 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 21 Hammock Trail 21220 Funeral **USA** Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Secretary Doctors Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Downey Guzinski ၉ Marianna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard T. Kitko (husband) 21 Hammock Trail Middle River Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Sacred Heart of Jesus 10/01/07 4 ☐Donation 5 ☐ Other (Specify) Dundalk, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Juneral Service Licen 1407 Old Eastern Avenue Essex MAryland 21221 art1 Enter the disease, or hoc , or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lly one cause on each line. Approximate Interval Between Onset and Death immediate/ ause (Final diseas for andition resulting death) Physician -If (NOSI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Listate of Figure that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ♠ No 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has t 24a. Was an autopsy performed? Yes No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 🎾 No Hospital: Other: 4 Nursing Home 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

> State Registrar

29b. Signature and title of certifier

Opkwood Road Glen Burnie MUNESED 7845 31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

29c, License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04:10PM September 24,2007 Kempf, Sr. W. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton 6006 Bedford Lane 8. Date of Birth March 1934 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F 73 116 26 5470 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other then "naturel", or Items 23s or 28s-f show traumstic event, the Mudical Exarch or court be collified at 1 ☐ Yes XXNo Maryland Prince George's Clinton Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20735 6006 Bedford Lane Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes XXNo If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes X2X No Specity: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Elevator Construction Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Depertment of Health and Mental Hy Important: If Item 27 is marked oth any liylury or other traumatic event 2018. Be Marion Agnes Dean John Joseph Kempf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jane Kempf (Wife) 6006 Bedford Lane, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 0ct1, Date 200720a. Mythod of Disposition

1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery
Lee Funeral Home, Inc. Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) eral S. rv . Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20735 23s. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12 heimer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physicien end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown cete has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 ☐ Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sept 25, 2007 D0053235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Darryl Hill, M.D. 13635 Baltimore Avenue Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

SEP 2 8 2007

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Robert Craig Kenn			of Maryland				and Mental H	łygiene	21	007 3122
	R	- For State egistrar		Cer	uncate	of Death		2. Date of Deal	eg. No.	3. Time of Death
Physician Medical Examine	4	n Decedent's Name (First, Middle,Last Robert Craig Kenn						Month Septembe	Day Year er 19, 2007	2210 hrs
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Funeral		5. Social Security Number 6. Se	x 7. Ag	je (In yrs. la	st birthday				th(MM/DD/YYYY) 9.	reign
Director	-	216-74-3890	M 2 F	45		Yrs. Months	Days Hours Mi	Oct. 1	2, 1961	Country) Maryland
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eath v items	Funeral	1 X Never Married 2 Married	Armed Forces	? X No		If Yes, specify	Cuban, Mexican, Puer	to Rican, etc.)	White, et	c.
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115-		Arthur L. Kenney					Muriel	Bloss		
212 212 Ment bould		19a. Informant's Name/Relationship ((Street and Number of			
MD 12 shc th and th and unmarit		Muriel B. Kenney	/ Mother				n Lane, N.		la, Maryla	nd 20852
Te, I and I'lear I'lear I'lear		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from S			isposition (Name or other place)	of cemetery, Se	pt. 26,	20c. Location - Ci	ly or Town, State
Pages Pages nent of ant: 1		4 Donation 5 Other Specify		Mont	gomer	y Cremator	rium, Inc. 20	007	Bethesda	a, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Lice	ise)			Robert A.	decess of Facility Fun	neral Home	/Rockville,	Inc.
	4	23a. Part I. Enter the disease, or com	lightions that cause	MOO89	Po not e	300 W. 1	Montgomery	Ave., R	rest, shock, or heart	Approximate Interval
Physician / lical		failure. List only one cause on e	ach line.			Intoxic		17.11		Between Onset and Death
aminer		Immediate Cause (Final disease a or condition resulting in death)	Due to (or as a con:			IIICOXIC	acion			
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tox 68760, eath certificate be ex eath certificate by eath eatherding physician for use as the burial	ِ اِ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ome of preg	nancy 2	Fetal death	3 Ectopic pre	gnancy	23d. Date of de Month	Day Year
x 68 h certi tendin use a	ig	past 12 months?	4 Pregnant	at time of d		Other (Spec	ify)		1	
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cords, P.O. B law requires that the d has been signed by the	집	Part II. Other significant conditions	contributing to dea	ath but not	resulting ir	the underlying	cause given in Part I.			Probably 4 🗸 Unknown
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be rs after death all Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	Be	25. Was case referred to medical examiner?	Hospital:	tient 2	ER/Outr		Other Nu		Y Residence 6-✓	Other: Scene
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r IIosr 24 ho e Fund etely f	ia O	29a. Certifier 1 Certifying Physi	cian: To the best of	my knowle	dge, death	occurred at the	time, date and place, opinion, death occurr	and due to the ca	iuse(s) and manner a	s stated. e to the cause(s)
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical		er:On the basis of ex and manner state	d	anu/or inv		License number	or are arrie, da		(Month, Day, Year)
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		ceshe I		f dooth /li-	m 22a\					
2 HK PIND		30. Name and address of person who Tasha Greenberg MD.	Assistant Med			111 Penn S	treet, Baltimore,	MD 21201		
Sta	ate	31. Date filed (Month, Day, Year)		ar's Signa				-		
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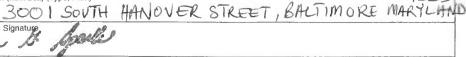
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Registrar

MUTALIB ADJE! 32. gistrar's Signature

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)



Seviember 25,2007

	_	For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mary		rtment of Hotelicate of L		nd M		g. No.	007	3 1 2 2	
Physicia /Medic	al .	WEN			LUI	Lacation		Month SEPTEM	1	Year 5 2007 nty of Death	1451 P	
Examin	-3.0	4a. Facility Name (If not institution, give st			4b. City, Town, or				40. 000	N/A		
Funeral Director		THE JOHNS HOPKINS 5. Social Security Number 414-02-3990 6. Sex	HO5PITAL 7. Age (li M 21 ✓ F	n yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth	924		place (State or Fore	
g		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
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with u	Ē	10e. Street and Number 12009 Robson St	noot			23233				S.A.	,	
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within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	<i>during</i> most	of worki	ng	16b. Kind o	f Business/Ir	ndustry	
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	To Be C	17. Father's Name (First, Middle, Last) Cheng-Ching Lo	•			Sho	ou-y:	in Tung				
s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship <i>(Typ</i> HSUN Lui — Husband	e, Print)		ng Address <i>(Street a</i> 109 Robsor		et	Richmon	d, VA	23233	3	
pernit. Pages 1 a Dep. dment of Hei Imp. ctant: if item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Hilltop	Service (Corp.(09/27	7/2007	Towso		yland	
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/Medical Examiner	16		HYPE	consequence of): RKALEM consequence of):	±Α						5 HIN	
ate be executed hysician and he burial-transit	Ical Examiner										1 Har	
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uires that I n signed by ild be deta	d by Ph	Part II. Other significant conditions con PANCREATIC N	tributing to death but		underlying cause giv	en in Part I		23e. Did to 1 ☐ Y	~		the cause of death	
The law requir ate has been si page 2 should i	Completed by							24a. Was a autop: perfor 1 \(\text{Yes} \)	sy	prior to death?	topsy findings availa completion of cause 2 \(\text{No} \)	
sien: ertifica ctor.	Be	25. Was case referred to medical examiner?			104		e of Deat	h (Check only or	ne)			
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To the within 2 To the comple	Me	29b. Signature and life of certifier	()		29c. Licens	se number			29d. Date s	signed (Mont	h, Day, Year)	
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St Regist	ate	30. Name and address of person who convince of the state	O. THE Jo	S Signature		AL G	DO N.	WXFE.	ST (3)	ALTIPE	RE ND ZI	

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death	Reg. No.	200	7 3122
Physician/ dical Examiner		ate of Death lonth Day eptember 24, 2		Time of Death 1608 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 212 Sycomore Road Glen Burnie	A	. County of Death nne Arundel	
Funeral Director	214-82-1807	Date of Birth(MM/I 08/31/19	DD/YYYY) 9. Birth Foreign Cour	14.1
d how any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md Anne Arundel Co. Glen Burnie			0d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once	10e. Street and Number 1 Wendover Rd. 21060		zen of What Countr	y?
™ £ a	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	n, etc.)·	14. Race - America White, etc.	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. The man 1 liten 27 is marked other than "uatural", or ite or other traumatic event, the Medical Examiner must To Be Completed by Funn	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) No specify: 16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)		Specify: Who	
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "untu e event, the Medical Exan To Be Completed	9 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First)	st, Middle, Maiden	Homes Surname)	
21218 could be fill d Mental F s marked tic event, I	George Mack Joan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		Schlicth lity or Town, State,	
e, MD 1 and 2 shc Health and item 27 ls r traumati	Diane Russell, cousin 136 Louise Terrace Gle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date of Disposition (Name of cemetery, crematory or other place)	,		
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory 21. Shall be 1 Funeral Symbol Cose. 22. Name and Address of Facility Gonce		altimore, L Service	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations. List only one cause on each line.	altimore, piratory arrest, sho	Md. 212 ock, or heart	25 Approximate Interval Between Onset and
/Medical taminer	Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of the liver Due to (or as a consequence of):			Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		1 11	17.
760, Toate be executed physician and the burial - transit	events resulting in death) Last Due to (or as a consequence or):			
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Box 68760, re death certificate be executed refer the attending physician and hed for use as the burial - trans Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		d. Date of delivery Month D	ay Year
P.O. Bo s that the de- gned by the a e detached for by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to t	he cause of death?
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tifical The Co	25. Was case referred to medical 26.Place of Death (Check only	Line Lond	10 10	
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on of V nding Phy th. r: After th te funeral c	1 V 11es 2 110	d. Describe how in	jury occurred	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director. edical Certification: To Be (2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street or Town, State)	and Number or Rui	ral Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e to the cause(s) a e time, date and pl	nd manner as state lace, and due to the	ed. e cause(s)
F ≱ F S	29b. Signature and title of certifier 29c. License number O.C.M.E.		Date signed (Mor ptember 25, 2	
otped	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
State Registrar	31. Date filed (Month, Pay Year) SEP 2 8 2007 SEP 2 8 2007			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** eptenber 18, 2007 Eleanor Elizabeth Mansolillo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner harlestown -atons v timore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March 30, 1920 | New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗙 F 577-28-0931 87 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Catonsville 1 ☐ Yes 2X No Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 21228 U.S.A. 709 Maiden Choice Lane #137S by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the sith and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Operator Telephone Company permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, <u>1</u>1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Siver Clinton George Webb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Cobblestone Court Ellicott City, MD 21043 Walter W. Mansolillo (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 9-21-2007 Silver Springs, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part . Enter the diseas or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosc erotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (it as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician I for use as the buna Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 2

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29b. Signature &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Choice Lane Batimore, MD 21228 711 M laiden 32. Redistrar's Signature

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 2:45 A.M. Baltimore, Maryland 21215-0036 SEPTEMBER 28, 2007 Physician /Medical

Physicia /Medic Examin

Funeral Director

Examiner Division or Vital Records, P.O. Box 68760,

MIHM, ANNA

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, I						2. Date of Dea Month	18, 200'	Year	3. Time of Deat				
Anna D. Mihr	n					Sept 2			2:45 A				
	tution, give street and number)		- ,,	n, or Location	of Death		4c. County	imore					
Stella Maris		ge (In yrs. last birthd	Timoni	_	24 Hrs.	8. Date of Birth			ace (State or For				
5. Social Security Number 214-40-2971	1 M 2 M F	95 Yrs	Months D	ays Hours	Min.	1/21/15	112	Mary]	Land				
Usual Residence of Decede 10a. State 10b. Co		10c. City, Town or	Location					10	0d. Inside City Lin				
	ltimore	Glen Arn					1 ☐ Yes 2√2N						
MD Ba. 10e. Street and Number 13005 Dulaney 11. Marital Status 1 □ Never Married 2□	y Valley Road		10f. Zip Co 21 05				l0g. Citizen of	What Coun	try?				
11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Deceden	of Hispanic O	rigin? (Spe	cify Yes or No-	14. Ra	ce - America					
1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div	Married 1 ☐ Yes 2 ▼	No	1 ☐ Yes 2K			moun, oto.)		by: Whit in the first th					
15. Decedent's Education 16a. Decedent's Usual Occupation 16b (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)									dustry				
3 Widowed 4 Div	-12) College (1-4or	54)	e. <i>Do Noi use i</i> H <mark>omemak</mark> e:				Own 1	Home					
17. Father's Name (First, M	17. Father's Name (First, Middle, Last) 18. Mcther's Name (First, Middle, Maiden Surname)												
Henry Linsen	meyer				y Mil								
19a. Informant's Name/Rel		1	ailing Address (S										
Ferdinand A.	Mihm Jr. / So		005 Dula			(080 L1	en Arm	<u> </u>					
20a. Method of Disposition 1 □ Burial 2 □ Crema 4 □ Donation 5 □ Ot	ation 3 Removal from State	cemetery,	isposition (Name crematory or othe deemer Co	rplace) ;			20c. Location Baltim	,	Maryland				
21. Signature of Funeral Sa			22. Name and A			Towson,							
Maca	u ago							050 Yo	ork Road				
23a. Part1. Enter the disea shock, or heart failure	se, or complications that cause List only one cause on each	ed the death. Do not li ne.	enter the mode of	f dying, such a	s cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Deatl				
Immediate Cause (Final disease or condition	Immediate Cause (Final disease or condition resulting in death) a. Preumon a.												
resulting in death)	Due to (or a	s a consequence of)		1	-	1			Manth				
	Sequentially list conditions. b. Ong Sture Heart Torrore												
Sequentially list conditions	Due to (or a	a consequence of)											
Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	J											
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of)	;										
<u>u</u>								1					
000	u												
IF FEMALE: 23b. Was decedent pregnation the past 12 months	23c. If yes, outcom		_				23d. D	ate of delive	ery				
in the past 12 months	2 ILLIVE DITUI	2 ☐ Fetal death at time of death	3 ☐ Ectopic preg 5 ☐ Other (spec				N	fonth	Day Year				
1 Yes 2 No 9 Unknown	9□Unknown												
Part II. Other significant c	onditions contributing to death	but not resulting in th	ne underlying cau	se given in Par	t I.	23e. Did to	obacco use co	ntribute to t	he cause of death				
Completed by						10,	Yes 2. No	3 ☐ Prob	oably 4 □Unkr				
lete						24a. Was		. Were auto	psy findings avai				
<u> </u>							osy rmed? 2\sumbole No	prior to co death? 1 Yes	mpletion of cause				
	nedical			26 Pla	ce of Deat	1 Yes h (Check only o		1 1 1 6 3	20110				
examiner?	Hospital: 1 ☐ Inpa	tient 2 ☐ ER/Outp	atient 3 DOA	Other:		me 5 Resi		ther (Specia	fr()				
27. Manner of Death	28a. Date of Ir	ijury 28b. Tir	ne of 28d	Injury at Work?		28d. Describe							
1 Natural 5	Pending (Month, Envestigation	Day Year) Inji	ury M	Work? 1 ☐ Yes 2 []No								
2 ☐ Accident 3 ☐ Suicide 6 ☐	Could not be 280 Place of i	njury - At home, farm	n, street, factory, o	office		28f. Location (Street and Nun	nber or Run	al Route Number,				
4 ☐ Homicide	determined building,	etc. (Specify)				City or To	vn, State)						
Ö (Check only 2 ☐ M	ertifying Physician: To the be edical Examiner: On the basis	of examination and/	death occurred at or investigation, i	the time, date n my opinion, d	and place, leath occur	and due to the red at the time,	cause(s) and i	manner as s e, and due t	stated. to the cause(s)				
one) 29b. Signature and title of	and manner	SIRIURU.	29c. J	icense numbe	r		29d. Date sign	ned (Month,	Day, Year)				
1 An	estino (Vra lit	- WD	DS:	279	40	Sep	temb	en 28"				
30. Name and address of	person who completed cause o	f death (Item 23a) (T	ype, Print)				1	`					
	RIGHT, M.D.	2300 DUL	ANEY VAL	LEY RO	AD	TIMON	IUM MI	21	.093				
te 31. Date filed (Month, Day	2 8 2007 32 Regi	strar's Signature	JOBNES)										

Registrar

I		For State Registrar	State of Maryla			nt of Health an te of Death	d Men		ene g. No. 20	07	312	29
2.		Registrar Decedent's Name (First, Middle, La	st)					ate of Death			3. Time of D	Death
Physici /Medic	_	Harry		Milla	rd			nonth otembe	Day 25	Year 2007	11:51	М
Examin	-	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death					4c. County	of Death		
		Johns Hopkins 5. Social Security Number 6.5		(In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				ate of Rith	,	0 Piethol	non (Ctata a-	Familian
Funeral Director			2 F 7. Age (III yill	S Yrs.	Months		Min.	Date of Birth	129	9. Birthpi Count	ace (State or	roreign
land ow t		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation			, ,		10	d. Inside City	/ Limits
e Marylar 3a-f show tiffed at	ctor	Md		Ba	Hi	nore					1 Yes	2 No
I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	rea Terr	000	10f. Z	21204	,	10	g. Citizen of ' $\cal U$	What Coun	ry?	
ems 2	ınera	11. Marital Status	12. Was Decedent Ever in Armed Porces?	U.S. 13.	Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specify Puerto Ricar	Yes or No-		ce - America		
irs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1		1 ☐ Yes			,	Specif	71	ick,	
72 hou natura lical E	ted	15. Decedent's E (Specify only highest gra	ducation			ual Occupation	f working	1	6b. Kind of B	usiness/Ind	ustry	
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filed v Hygie other t		17. Father's Name (First, Middle, Last	")	1717117	ury_	18. Mother's	Name (First	st, Middle, M.	aiden Surnar	ne)		
2 should be filed withing and Mental Hygiene. is marked other than aumatic event, the Mental Hygiene.	To Be	Harry Milla	rd			Ne	Hie	11/2	em	5		
and 2 sho ealth and n 27 is m	0.7	19a. Informant' Name/Relationship	Crype. Print) daughte	19b. Maili	ng Addres	s (Street and Number of ScaTerra	7	ute Number, 2.Him 0		, State, Zip	Code)	
permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once.	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	20b.	. Place of Dispo	osition (Namatory or	me of other place)	Date	2	0c, Location	- City or To	wn, State	1
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permit. Departm Importa any Inju		21. Signature Funeral Service Lice	nseen MAAA	ne I	1 wg	pd Address of	enc	L TEU	reral 72.11.			2
MANAGE OF THE PARTY OF THE PART		23a. Part I. Enter the Jasese, or com	pplications that caused the de	ath. Do not en		de of dying, such as ca	rdiac or res	spiratory arres	Ballo st,	Md.	Approximate Interval Betw	
Physician	b y	shock, or heart lafure. List only Immediate Cause (Fmal disease or condition	a. Sepsis								Onset and De	eath
/Medical Examiner		resulting in death)	Due to (or as a conse								10. 10	
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n certiff	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg		¬=				23d. Da	ate of delive	ry	
The law requires that the death certific the law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic □ Other (pregnancy pecify)			M	onth	Day Ye	ear
that thed by 1		Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying	cause given in Part I.		23e. Did toba	acco use con	tribute to th	e cause of de	ath?
quires an sign uld be	ed by						_	1 ☐ Yes	s 2🔀 No	3 ☐ Prob	ably 4 ∐Ur	nknown
law re as bee 2 shor	Completed							24a. Was an autopsy		Were auto	sy findings a npletion of ca	vailable
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ician certifi	Be	25. Was case referred to medical examiner?	Hospital:			Other:		eck only one				
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nding ith. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)		М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			,			
r Atte ter des irecto	Certification:	3 Suicide 6 Could not be determined		home, farm, st c <i>ify)</i>	reet, facto	ry, office	28f. l	Location (Str. City or Town,	eet and Num State)	ber or Rura	Route Numb	per,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 🛣 Certifying P	hysician: To the best of my k	nowledge, dea	th occurre	d at the time, date and	place, and	due to the ca	use(s) and m	nanner as s	ated.	
n 24 hc n 24 hc ne Fun bletely	edical		miner: On the basis of exami and manner stated.									
To the within To the comp	Me	29b. Signature and title of certifier				9c. License number			d. Date signe			
		Fasika Work				RES-00	00	Se	eptemb	er, 2	5,20	67
10		30. Name and address of person who				1 0. 1.10 - 22		112 0	h/1	1	7/16	7
Sta	at <u>e</u>	Fasika A. Woreta, J. 31. Date filed (Month, Day, Year)	ohns HopKins H 32 gegistrar's Sig	nature	605 N	iorth wolte Stre	e+, 6a	Itimore	IVIATY	land	2120	/
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DHMH 17 Rev 1/2001

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23a. Part : Enter this dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or head faiture. List only-able cause on a search line. Immediate Cause (Final death) Sequentiation (all only-able cause) Sequentiation (all only-able cau	altim mit. Pa partmen	-	4 Donation 5 Other Specify:		Services
failure. List only-dire cause on each line. The companies of the compan		_	Vaugh C. Irleve 5151 BaHo. Nat 1 P	espiratory arrest, sh	229) lock, or heart Approximate Interval
or condition resulting in death) Due to (or as a consequence of): The condition is sequentially list conditions, if any, leading to immediate value. Exist thicknying Cass-sequence of):	Medica	0.0	failure. List only one cause on each line.		
Second Column The column	xamine	l			
(Nesease or injury that initiated events resulting in death) Last of events resulting in the underlying cause given in Part I. [Inspect of Death (Check only one)	•	ner	if any, leading to immediate Due to (or as a consequence of):	1 -0 8	
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The part of the pa	60, ate be e obysicia	Medi	#23a,27,28a-f, perME,g872, 10/12/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy		
The standard of the standard o	r 687 certific	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)	су	Month Day Teal
The standard of the standard o	Box ne death the atte	hysi	1 Yes 2 No 9 Unknown 9 Unknown	23e, Did tobacc	o use contribute to the cause of death?
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	P.O.			1 Yes 2	No 3 Probably 4 ✔ Unknown
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	rds, require been si	leted		autopsy	prior to completion of cause of
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	Reco	gmo		1 Y Yes 2	
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	Ital Fiction:	Be	25. Was case referred to medical examiner? Hospital: A longition 2 ER/Outnatient 3 DOA Other Nursing		dence 6 🗸 Other: Scene
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	of Vi g Phys fter this	1: To	1 V Yes 2 No 27 Mapper of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe how i	njury occurred
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	sion trendir death.	ation	Natural 5 Pending Pending Investigation Prind 9/19/2007 Find 12:57 pm 1 Yes 2 X No		t and Number or Rural Route Number, City
29b. Signature and title or certifier James Jell Mp O.C.M.E. September 20, 2007	Divisor A at Direct A list or A	artific	3 Suicide 6 X Could not be determined (Specify) found in vacant building		
29b. Signature and title of certifier James Jell Mp O.C.M.E. September 20, 2007	Hospid 24 hours Funer			due to the cause(s)	and manner as stated. place, and due to the cause(s)
famellel nun O.C.M.E. September 20, 2007	To the To the To the	Comp.	2 Medical Examiner: Of the basis of examiners of an and manner stated. 29b. Signature and title of certifier 29c. License number		
		-	1 A COME	S	eptember 20, 2007
			30. Name and address of person who completed clause of death (Item 23a) Techo Croophord MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201	
State 31. Date filed (Month, Day, Year), 32. Resistrar's Signature	/0	Stat	Tastia Greenberg MB.		
DHMH 17 Rev 1/2001 OCMF ORIGINAL		istra	and the same of th		

07-07563 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Melchiore State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 26, 2007 1225 hrs Medical Examiner J. Melchiore 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore University Hospital 5. Social Security Number if Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex **Funeral** Forei**P**ennsylvania 167-24-5942 Months Days Hours Min Director 75 1 X M 2 Yrs 01-08-1932 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County 1 Yes 2 X,No 28a-f show PA Delaware Glen Mills items 23a or 28a-f shovnst be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Heath and Mental Hygiene.

If I tem 27 is marked other than "natural", or items 23a or 28a-f she Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 19342 313 Fox Terrier Court U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. or other traumatic event, the Medical Examiner must be Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes Yes 2 X No specify: White Widowed Divorced Yes, Give Yee Specify: by 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 5+ Chemist Sun Oil 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mcanany John J. Melchiore
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Melchiore- Wife 313 Fox Terrier Court Glen Mills. PA 19342 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Peter & Paul Cem. 09/29/2007 Marple Township, PA 4 Donation 57 22. Name and Address of Facility 21. Signatu 5305 Harford Road Vice Li ensee Leonard J. Ruck, Inc. Baltimore, MD 21214 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disea. , complication failure. List only one are e on each line Approximate Interval Physician Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury may inmated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - trans Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, detached for 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of After this certificate has performed? death? 1 🗸 Yes No Yes 2 No To the Hospital or Attending Physician: Th within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, px 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other, Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes No 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Sep 25, 2007 Pedestrian struck by auto 2005 hrs Natural 1 Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Lombard Street at Calvert Street, Baltimore, MD determined (Specify) Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Signature and title of certifier 29c. License number O.C.M.E. September 27, 2007

Registrar DHMH 17 Rev 1/2001 OCME 2006

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State

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32 Registrar's Signatur

LE MILLEN

30. Name and address of person who completed cause of reath (Item 23a)

OCMF

Patricia Aronica-Pollak MD.

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8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #5 Per FH G872 10/03 efficient of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 24, 2007 **Physician** 2:31P M CHRISTOPHER JOHN MEAD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stone Park Place Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 212-90-9826 7. Age (In yrs. last birthday) **Funeral X**X M 2□ F Months Days Hours Maryland December 4,1962 212-09-9826 44 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10d. Inside City Limits 10c. City, Town or Location Directo Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4 Stone Park Place 21236 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 White þ XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Process Server Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lawrence Mead Sr Mary Ellen Terry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ellen Mead Mother 427 Hopkins Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐Burial XX Cremation 3 ☐ Removal from State Green Mount Crematory 10/1/07 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final Physician resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1□ Yes 2No 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 28 Place of injury Suicide by hanging
281. Location (Street and Mimber or Rus) Roun Number,
City or Town, State) 45 Tone Park Place
PEMY Agil M ZIZ 36 within 24 hours after death.

To the Funeral Director: Af completely filled in by the fun 1 | Yes 2 | No 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide Place of injury - At hor building, etc. (Specify, At home, farm, street, factory, office determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Trimble Hill CT. Lutherville, Md 21093

completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician ILENE** SEPTEMBER 25 2007 h 4c. County of Death MOSES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON , Dam If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 Days Hours 75 PA 166-24-4865 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2302 HANWAY ROAD 21209 U.S.A. Funeral 7/25/21 Moses Iren Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) REUBEN LEVINSON HARRY IDA ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON MOSES / HUSBAND HANWAY ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1 CONG. 09/26/2007 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. HAR SINAI CONG. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer montres /Medical Due to (or as a lonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Erns Uncoyling Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760. Physician/Medical SS IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9□Unknown 9 Unknown has been signed by e 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 autopsy performe 2 No 1□ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 일 1 Yes 2No 1 Inpatient 2 ER/Outpatient 3□ DOA 6 Other (Specify) # 05 Pice After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury 28c. Injury at Work? Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 25 2007 29b. Signature and title of certifier 29c. License number 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARRON J. CHARLES M. 701 N. Charles T. Towson, mo 2120+

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 8 2007

22. Registrar's Signature

07-07510 Andrew McQuade

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Certificate of Death						Re	g. No. 2	UU	1 3123
/ledic	Physici cal Exami	an/	1. Decedent's Name (First, Midd Andrew							Date of Death Month September	n Dav Yea		3. Time of Death 0844 hrs
			4a. Facility Name (if not institution 4107 Doris Avenue	on, give street and nu	umber)		4b. City, Town, o Baltimore	or Location o	of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 217–02–1244	6. Sex	7. Age (In yrs. Ia	ast birthday) Yr:	If Under 1 Ye Months Da		Min	3. Date of Birti		Foreign	hplace (State or n untry) MD
į.	nd show any ce.	_	Usual Residence of Decedent 10a. State 10b. County MD		10c. City,	Town or Loca	Baltim	ore					10d. Inside City Limits 1 X Yes 2 No
	th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 4107 Doris A	Avenue		10	g. Citizen of W USA	hat Coun	try?				
-	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo								, Puerto Ric	can, etc.)	14. Race - American Indian, Black, White, etc. White Specify:		
36	led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)	during r	nt's Usual Occupa nost of working lif truction	e. DO NOT	use retired		16b. Kind of Be		action
21215-0036	5 E E E	Be Com	17. Father's Name (First, Middle Andrew Dewey		Jr.				,		aiden Surname tingtor	=)	
MD 21	I and 2 should I Health and Mer item 27 is mar	户	19a. Informant's Name/Relations Robin D. Enr		er		ng Address (Stre 9 Eutaw						, Zip Code)
altimora	S = 5		20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other S	inecify:	rom State B	crematory or o ayview	sition (Name of co ther place) Cremato	,) _{ate} /2007	20c. Location Balt		Town, State
Ralt	part por		21. Signature of Funeral Service	0			Name and Addres Charles 1501 Fas	L. Ste	evens t. Ave	Funer	al Home altimor	Inc	ii 21230
	hysician Wedical caminer		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. <u>Cardiac</u>	caused the death arrhythm a consequence o	ia	the mode of dying	g, such as ca	ardiac or re	espiratory arre	st, shock, or he	eart	Approximate Interval Between Onset and Death
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener uncertying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dilat Due to (or as a	ed consequence of a consequence of	megalv f):							
_	ficate be executed g physician and the burial - transit	/Medical	X UNPENDED	d. X #MENDED	,27,perME	L,g872, 1	0/1/07 TT						
Box 68760	E 60	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Ur	the 23c. If yes,	outcome of preg birth nant at time of de	nancy 2 F	etal death 3 other (Specify)	Ectopio	c pregnanc	у	23d. Date o Month) Day Year
	res that the c signed by the	<u>آھ</u>	Part II. Other significant condi			esulting in the	underlying cause	e given in Pa	art I.				the cause of death?
Division of Vital Records	To the Hospital or Attending Physician: The law requires that the death certificate by the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed								24a. Was a autops perform	sy m <u>ed</u> ?		topsy findings available completion of cause of
f Vital E	Physician; The rthis certificate ral director, page	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatien	nt 3 DOA	Other	Nursing H	dome 5 1	Residence 6		: Scene
o doisi	or Attending Phafter death. Director: After tin by the funeral	ertification:	1 X Natural 5 Pen 2 Accident Inve	ding estigation	h, Day,Year)	-5		Yes 2	No	3f. Location (S	treet and Numb		ral Route Number, City
į	To the Hospital or At within 24 hours after d Fo the Funeral Direct completely filled in by	0	4 Homicide dete	ermined (Specify,	st of my knowled	_					e(s) and manne		
	To the Howithin 24 h To the Fur	Medical	one) 2 Medical Example 29b. Signature and title of certification 200 and 200 are signature.	aminer: On the basis and manner: er		ind/or investiga	29c. Licer	nse number	ccurred at th	ne time, date a	29d. Date sign	ned (Moi	nth, Day, Year)
6	(3)		30. Name and address of person	n who completed caussistant Medical			Street, Baltin	M.E.	21201		Septembe	a ∠5, ∠	
U	St Regis		Carol Allan, MD As 31. Date filed (Month, Day, Year)		egistrar's Signat		Sueer, Dai(III		, 21201				
	regis	गया	- SELX &	CUUI PROGRAM	7000								

			1- State of Maryland / Department of State of Maryland / Department of Certificate of Certi		ntal Hygien Reg. N	2001 31233
	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Coles Nabors		Date of Death Month Date	3. Time of Death
	/Medic			vn, or Location of Death	estenla	c. County of Death
	Examir	ier	A A	Washing ton		Prince Cerry's
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	ear If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year V 1, 192	9. Birthplace (State or Foreign Country)
	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Maryli a-f sho tified al	ctor	Maryland Prince George's Fort Washing	ton		1 □Yes XX No
	ath with the 23a or 28 ust be no	Funeral Director		0744	Un	itted States
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 □ No Korean 1 □ Yes 2 □ No Korean 1 □ Yes 2 □ No Korean	of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric X No <i>Specify:</i>	y Yes or No- ean, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	vithin 72 h ne. han "natu Medical	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	one during most of working etired)	1	Kind of Business/Industry Prince Goerge Co. rd of Education
2	filed v Hygie ther t		12 6 Administra 17. Father's Name (<i>First, Middle, Last</i>)	18. Mother's Name (Fi		
lan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	Harvey Andrew Nabors		Shelton	
, Maryland	1 and 2 should Health and Men tem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Martha Irene Nabors (Wife) 19b. Mailing Address (St	reet and Number or Rural Reren Drive, Fc	Route Number, City Ort Washi	or Town, State, Zip Code) ngton, MD 20744
nore	Pages 1 and the pages 1 and the pages 1 and the page 1 and the pag		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other Lee Crematory			Location - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.					ome,Inc 6633 01d
	70 E 9 9		Alexandr	ia Ferry Road		
	Physician /Medical		23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	rdioVAs eul	av Kan	Approximate Interval Between Onset and Death
	Examiner	L				
لم	uted	Examiner	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
68760,	ficate be executed g physician and ss the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of):			
		fedi				
O. Box	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specification)			23d. Date of delivery Month Day Year
rds, P.	quires that n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		o use contribute to the cause of death? 2 No 3 Probably Doknown
or Vital Records,	The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performed? 1□ Yes 2□	
/ita	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examing and	26. Place of Death (C		
0	Phys this al dir	은	1 ☐ res 2 ☐ No			6 □Other (Specify)
	ing After une	tion:	1 Natural 5 Pending (Month, Day Year) Injury	Injury at 28d Work? 1 ☐ Yes 2 ☐ No	I. Describe how inj	ury occurred
Division	- 0 - C	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)	ice 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in and manner stated.			
	To the To the Comp	M	29b. Signature and title of certifier 29c. Lie	cense number		late signed (Month, Day, Year)
	- ()		favodor /ffiele 90	40053921	7 Se	otember 27, 2007
	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADOV SUVENTEN 3001 H250 TEUL	Drive C	Lever l.	May and
	Sta Registr		31. Date filed (Month Day, Year) 38 Registrar's Signature		3	, , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		•	1 - State Registrar	Cert	tificate of	Death	Reg.	No.2007	31236	
	Physici	an	Decedent's Name (First, Middle, Last) OTTO DDD 4	Nom			Date of Death Month	Month Day Year		
	/Medic	544	GIUSEPPA	NOT			SEPTEMBE			
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Death		
			1604 DEER MEADOW COURT 5. Social Security Number 6. Sex 7. Age (In yrs. last	t hirthday)	HANO	VER If Under 24 Hrs.	8. Date of Birth	ANNE ARU	NDEL hplace (State or Foreign	
	Funeral Director	1	212-40-5846 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 11/7/191	ear) Cou	untry)	
	and		10a. State 10b. County 10c. City, T	own or Loc	cation				10d. Inside City Limits	
	Maryl f sho led a	or	MD ANNE ARUNDEL	HANO	VER				1 □Yes 2 No	
	the 28a-	Director	10e, Street and Number		10f. Zip Code		10g.	. Citizen of What Co	untry?	
	with sa or	٥	1604 DEER MEADOW COURT		21070	6		SICILY		
	ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. W		lispanic Origin? (Spana) an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	Hican, etc.)	Black, White	white	
2-0	72 hc natu Jical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup	during most of work	16t	b. Kind of Business/I	ndustry	
2	ithin ne. Me	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired	d) -		LOTHING		
	lygiel Inertl			<u> </u>	R-SEAMSTI		e (First, Middle, Mai	MANUFACT	URING	
pu	be fil ntal H id otl	Be	17. Father's Name (First, Middle, Last)					den Surname)		
<u>Y</u> a	2 should be and Mental is marked c	ပ္	LUIGI DESTEFANO	401 14 11		STEFANA			T- 0 - 1-1	
Maryland	d 2 sh h and 7 is n traun				•			ity or Town, State, Z		
e,	1 and Health em 27 ther to	1	STEPHANIE KURDYS/DAUGHTER 20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of	ADOW COUR		c. Location - City or	O76 Town, State	
Baltimore,	permit. Pages 1 and Department of Healti Important: If item 27 any Injury or other tonce.		1 Purial 2 □ Cremation 3 □ Removal from State	ietery, crem	natory`or other plac ALLEY MEI			CKEYSVILL		
亞	nit. Partme		4 □ Donation 5 □ Other (Specify) 21. Signature of Funer 1 = rvice □ consee /	APDEN	Name and Addre	ess of Fecility TH	F IOHNSON	CVEISATER	HOME, P.A.	
Ba	Depo Impo any	9	M. Illat Coloner	8	521 LOCH	RAVEN BL	VD. TOWS	ON, MD 2	1286	
	-		23a. Part1. Enter the disease, or complications that caused the death.						Approximate	
	Physician	6 19	shock, or heart failure. List only one cause on sach line. Immediate Cause (Final	WC	0 R	DNO A	55/	ANCON	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death) a. Due to (or as a consequent of the control of the co	nce of):		1/1/1	0) 0	1100	20/00.	
	Examiner			,					,	
	- S	Jer	Se uentially list conditions, if any, leading to immediate Due to (o, as a consequent cause. Enter Lindarying	ice of).				191		
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	certificate be executed rding physician and ise as the burial-transit		resulting in death) Last Due to (or as a consequen	ice of):						
68760,	ate b hysic the bi	Medical	d							
	ag d #	Med	IF FEMALE:							
.O. Box	death e atter id for u	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	eath 3 🗌	Ectopic pregnanc Other <i>(specify)</i>	у		23d. Date of del Month	ivery Day Year	
Д.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the un	nderlying cause giv	ven in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pr	the cause of death?	
or Vital Records,	Physician: The law rethis certificate has bee al director, page 2 sho	Completed					24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 \square No	
ita	ian: rtiffce xtor, p	Be C	25. Was case referred to predical			26. Place of Deat	h (Check only one)			
>	Physician: r this certific ral director,	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	t/Outpatient	t 3 DOA Oth	ner: 4 ☐ Nursing Ho	me 5 Residenc	ce 6 □Other (Spe	cify)	
ion o	Attending Pt r death. ector: After the funeral		1	8b. Time of Injury	Wor	ry at rk? IYes 2 ☐ No	28d. Describe how	injury occurred		
Division	tal or Atte s after der al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office	V).	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowle (Check only one) Certifying Physician: To the basis of examination and manner stated.	edge, death n and/er inv	occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
)	To t Withi	M	29b. Signature and title of certifier		29c. Licens	se number 5014	290	Date/signed (Mont.	h, Oay, Year)	
	H		30. Name and address of person who completed cause of death-(Item 2)	D /9	er de	300	Ton	8000	non	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 8 2007	Para	well)				•	

	Physici /Medi
	Examir
	Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
	Physician
	Physician /Medical Examiner
Division or Vital Records, P.O. Box 68760, *	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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		State of Ma	aryland		rtment tificate			nd Mer		giene Reg. No		3	12	37
		Registrar 1. Decedent's Name (First, Middle, Last)			imoaii	01 2		2.	Date of Dea	ath		3.	Time of D	Death
hysicia /Medic		Caroline Agnes O'Connell		-				Se	ptemb		6, 200		:30	Рм
Examin	er	4a. Facility Name (If not institution, give street and number) Madonna Heritage					Location of	Death			County of Dea ford	ıth		
ineral ector		5. Social Security Number 6. Sex 7. Ag 1	je (In yrs. la 98	st birthday) Yrs.	If Under Months	f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 31, 1908					- C	ountry)	(State or Germa	_
-		Usual Residence of Decedent 10a. State 10b. County		Town or Lo	cation								side City	
f shov ied at	tor	MD Baltimore	Monk		Jation								Yes 2	
r 28a	Director	10e. Street and Number	1.01111	-	10f. Zip	Code				10g. Citi	zen of What C	ountry?		
23a o ist be		17433 Wesley Chapel Road		21111						USA	JSA			
er mu	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.						Yes or No- an, etc.)	or No- c.) 14. Race - American Indian, Black, White, etc.			di <i>a</i> n,	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 V If Yes, Give X Year or Dates:	No	1 ☐ Yes 2 ☐ No Specify:							Specify:	whit	e	
'natur	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin						nd of Business	/Industry	/		
r than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 1)	5+)							vn Home				
vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Ma					Surname)			
arked atic e	T _o	Benedict Huber Carolina Buttinger												
7 is m traum		19a. Informant's Name/Relationship (Type. Print) Arthur E. O'Connell / son			•						n Town, State, 1,MD 2		*	
item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Nan	ne of		Date			ocation - City o			
ant: If ury or		1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	ney Val			· ;	10/1/0	07	Timo	onium,	MD		
Import any Inj once.	21. Signature of Fundal Service/Lice/Isee Ruck Towson Funeral Home Tows											York Road n, MD 21204		
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death.	. Do not ent	er the mod	e of dying	g, such as c	ardiac or re	espiratory ar			App Inter	roximate rval Betw et and De	een
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d by th		9 Unknown Part II. Other significant conditions contributing to death b	out not resul	Itina in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco u	use contribute	to the ca	use of de	ath?
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cate h									perfó 1∐ Yes	rmed? 2 No	death?			
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ter this neral di	n: To	27. Manner of Death 28a. Date of Inju	ury	28b. Time o		8c. Injury Work	4 Nurs		I. Describe I			есіту)		
tor: Af the fur	catio	2 Accident investigation			М	1 🗆 '	Yes 2□N							
od in by	Certification:	determined 266. Place of III	jury - At hor tc. <i>(Specify,</i>		eet, factory	, office		28f.	. Location (S City or Tox	Street an vn, State	nd Numbe r or F e)	Rurai Rou	ute Numb	er,
To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	dical	29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29a. Certifier (Chack only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.												
To t	Σ	29b. Signature and title of certifier On 1 Quest M 30. Name and address of person who completed cause of or 10 755 Falls Rb, 5u 18 31. Date filed (Month, Day, Year) SEP 2 8 2007	d		290	. License	50 4	14		29d. Da	te signed (Mor		Year)	
5		30. Name and address of person who completed cause of a 10755 Falls Ru. Su. 1	death (Item	23a) (Type,	Print)	JOH	N N.	Auc	DIA	MD				
Sta Registr	ite 'ar	31. Date filed (Month, Day, Year) 32. Regist	rar's Signat	ure	Scool	2		- + 4,48	Est. 6	7 7	-			
' Rev 1/2		JL1 4 8 2001/	MARKET .	Siring "	A STATE OF THE PARTY OF THE PAR	300								

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Dolores J. Olsen 4:50 PM September 24, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Dundalk 7849 Eastdale Road If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🔀 F Yrs Maryland Director Jan. 11,1919 216-18-9157 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X Ño Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21224 7849 Eastdale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Salesperson Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Zoubeck Emma Kesselring ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Leonard E. Olsen (Husband) 7849 Eastdale Road Dundalk, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem: 9/27/2007 5 ☐ Other (Specify) Baltimore, Maryland 4 Domation rnature of Juneral Sovie 200 ee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each lipe. Atrial Immediate Cause (Final disease or condition resulting in death) **Physician** F.brilla 10 years /Medical to (or as a consequence of): Examiner ertensive years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown OS4e0DO10515 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【 No 24a. Was an nas page 2: autopsy performe certificate 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) ပ this After this funeral c 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide the Hospital Typertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 Belair Rd. Baltimore Martin MO lichae 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1- State of Maryland / Registrar	Department of Health and M Certificate of Death	lental Hygien Reg. N	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physic		Joseph Pastorie			ay Year 19 2007 6:05 P M
1	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- Promise	c. County of Death
	LXdIIII	iei	1967 Chipper Road	Edgewood		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to		8. Date of Birth	Birtholace (State or Foreign
п	Director		218-18-9291 NOXM 2□F 82	Yrs. Months Days Hours Min.	(Month, Day, Year June 23, 19	925 Maryland
			Usual Residence of Decedent		June 23, 13	72.3 Maryrand
	ylan		10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland If fleath and Mental Hygiene, tiem 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Medical Evanture treumatic event, the Medical Evanture treumatic event,	ţò	MD Harford Edg	gewood		1 ☐ Yes 2√ No
	r 28c	lec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	38 o	0	1967 Chipper Rd.	21040	II	S.A.
	ms 2	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
(0	ter ter	F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		Rican, etc.)	Black, White, etc.
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21215-0036	2 ho	Completed		a. Decedent's Usual Occupation	16b. I	Kind of Business/Industry
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212	within jiene r than	Eo	8	Repairman		Appliance Repair
	filed Hygir other	O	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	
an	Mental Mental arked c	00	Joseph Pastorie	Cathe	rine Jones	
2	should nd Men marke imatic	P		9b. Mailing Address (Street and Number or Rura		
Maryland	id 2 sho ith and 27 is my treum		test to the second seco	ACM TO THE RESIDENCE OF THE PARTY OF THE PAR	07807	viceocal vicin
-	s 1 and if Healt item 2 other	1	Joseph A. Pastorie (Son) 17	O Long Drive, Queenst	own, Md	21658 Location - City or Town, State
Ö	a 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ery, crematory or other place)	200. 1	Location - City of Town, State
Ē	Pa men ant:		'4 □Donation 5 □Other (Specify) Parky	wood Cemetery 09/26	/2007 Bal	timore, Maryland
Baltimore,	pemil. Pag Deportment Important: I any njury o	t (21. Signature of Funeral Service Licensee	22. Name and Address of Facility	imunek Fun	eral Home, Inc.
8	80759	0 11	Dane Grade	9705 Relair Rd No	ttinchom	MA 21226
M			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
м	Physician		Immediate Cause (Final	1 Tutaretion		
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_	death certifica attending ph		IF FEMALE:			
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery Month Day Year
	e de the a	Sic	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		William Day (Sal
P.0	res that the de signed by the a be detached f	ڳ.	9 Unknown			
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Re	The law cate has page 2 s	E			autopsy performed?	prior to completion of cause of death?
a	ician: Th certificate ector, pag	Ö	25. Was case referred to medical	= 00 Bi	1 Yes 3 N	o 1 Yes 2 No
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of	Phys this ral di	-	1 Inpatient 2 EHVC	dipatient 3 DOA 4 Notsing Ho	me 5 V Residence 28d. Describe how inju	
	ding to	lo	1 Natural 5 Pending (Month, Day Year)	Injury Work?	200. Describe now inju	ary occurred
Sic	tend leath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		141
Division	or At iter of irect	Certification;	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	ital c					
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	cal	29a. Certifier (Check only) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and place,	and due to the cause(s	s) and manner as stated.
	he F in 24 he F plete	Medical	one) and manner stated.		oc at the time, date at	
<u> </u>	To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			Mema / Frenchan	51050		9/21/07
	m		30. Name and address of person who completed cause of death (Item 23a		Unalth C	System
)		Flena V. Sem	(Type, Print) V A Maryland POS Perry Point D		
	Sta	to	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	refry Point D	rerry	Point, Md. 21902
	Registi		SEP 2 8 2007 June 15	And Co		
			DELS O TOOL			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician а М Sept. 26 2007 5:30 Frank A Revnoc Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Elk Forest Court Elkridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 16, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Year) 1956 Maryland 51 220-66-7110 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Howard Co. Elkridge Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21075 5981 Elk Forest Ct. Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 0. Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) A.A. County Elementary/Secondary (0-12) College (1-4or 5+) Bureau of Highways 12 Supervisor is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank A. Revnoc, Sr. Agnes A. Bistransky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Marlene Wescoat, sister 5712 Franklin St. Balto. Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/01/07 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee manuoulu 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Paol. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mon /Medical Due to (or as a conseque e of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Director:

Medical

29a. Certifier

24 hours a within 2

> 10 State

> > Registrar

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

3001 South Hanover, Baltimore, MD 2/725 BENO, ND

31. Date filed (Month, Day, Year) SEP 28



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name 2. Date of Death 3. Time of Death EPT Year **Physician** eynolds 0815 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, 3-20-7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Months Days Hours 215-18-907 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits atonsville 1XYes 2 No Director 10e. Street and Nambe 10g. Citizen of What Country? ane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Sec ndary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnar Be REYNOLDS, ၉ 19b. Mailing Address (Street and Number or Ruya) Roule Number, City pr Town, State, Zip Code) PriBrand Daughter. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) le. 21. Signature of Funeral Service Licenses Pike, 5151 Balto. Nat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPATHY **Physician** imknown /Medical Due to (or as a consequence of): RENAL Examiner INSUFFICIENCY Ununown Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atten I be detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Be Completed by Tachycerdias 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054257 MD 2007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) MOSP. BALTIMORE MD-21229 AGNES 31. Date filed (Month Per, Year) Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend PI, line b perMD, 88/I, 9/28/07 TT Certificate of Death

Registrar

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** SMITH WAYNE 4:55 AM Sept 2067 /Medical 4a. Facility Name (If not institution, give street and number) B. City, Town, or B. City, Town, or B. City, Town, or B. Date of Birth (Month, Day, Year)

Months Days Hours Min. Sept. 18, 1953 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hosp 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F 54 Maryland 217-54-9966 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes X☐ No Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or ms 23a 8515 Old Harford Road 21234 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 5-0036 ō 1 ☐ Yes 2 No Specify: Specify: 9 3 ☐ Widowed 4 M Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Becton and Dickinson Fork Lifter Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Smith Evelyn Walker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a, Informant's Name/Relationship (Type, Print) 2825 Superior Avenue-Parkville,Maryland Carly Smith-daughter Department of Heal Important: If Item 2 any injury or other once. timore, 20b. Place of Disposition (Name of cametery, crematory or other place)

Evans Funeral Chapel Sept. 25, 2007 Forest Hill, Maryland 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) and permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bal 8800 Harford Road EVANS FUNERAL CHAPEL 8800 Harriard Road AND CREMATIONS SERVICES Parkville, Maryland 21234 Kondrae h TVI Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ThoxIc /Medical Due to (or as a consequence of): Examiner Alcohol Abuse Sequentially list conditions, the beauty to all the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician a s the burial-t Physician/Medical as signed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 has autopsy performe certificate 1□ Yes 2 No Division or Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient P 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 1 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of cept 53722 D 00

Registrar

State

31. Date filed (Month)

6000

32. Registrar's Signature

Someritan Horp Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Slagle Day 26 Month Year **Physician** 945 PM Elizabeth 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing 6. Sex Grace Hartoro 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2**X**F Hours Min. 19-24-2014 Director 11 Nov Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits a or 28a-f show be notified at Director 1 ☐ Yes 2 No Maryland Harfrid Count fares+ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21059 Stontes Rock Spring United item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be 1807 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mer-Le Brishess Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John rawmer ပ Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perryville, Mr. Kenneth Slast 554 Aiken Ave Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages I Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 28, 2007 Eneral Chaput Forest Hill, Marzland injury 22. Name and Address of Facility of a cremain Services Bel Ar Evans From Chapula Cremain Services Bel Ar 3. Nerport Drive, Front Hill, Manyland 2105 21. Signature of Funeral Service Licenses any ir Maryland 21050 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. yter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o. 9☐ Unknown 9 Unknown signed by ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has b irector, page 2 si 24a. Was an autopsy performed 2 100 1□ Yes & No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: ပ 1 ☐ Yes 2 🔭 🗓 1 Inpatient 2 TER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the I and manner stated. 29b. Signature and title of certifier 30. Name and address of person who comp 31. Date filed (Month, Day, 32. Registrar's Signature State SEP 28 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** GEORGE 1:00 a^M JOHN **STATHIS** September 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3312 Rosemary Lane West Friendship Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 225-76-1610 70 May 16, 1937 Greece Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2☐ No notified Director Maryland West Friendship Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i 21794 3312 Rosemary Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or iter 1 □ Yes 22 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🎞No Specify þ Specify: White 3 ☐ Widowed XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales/ Repair vears Restaurant Equip. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked or any injury or other traumatic ev Marigo Karaminja George J. Stathis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marigo Stathis / daughter 3312 Rosemary Lane West Friendship, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Mem. Park 10/02/2007 Clarksville, Maryland 21. Signature of uneral Se vice Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) ∣□Yes ed by the a detached f 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2**X**No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) Baltimore MDZ1244 ECURITY BIVE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** September 26. SUROCK AWRENCE 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death tos 7. Age (In yrs. last birthday) Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 213-28-4696 1**№** M 2□ F **Director** MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 21 TNo PERRY HALL BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral CHESTHILL COURT 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Ses 2 No 1 Research If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPT. OF RECREATION Elementary/Secondary (0-12) College (1-4or 5+) OUNSE 4 PARKS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ THOMAS SURECK MADELINE MOMO 19a. Informant's Name/Relationship (Type. Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21236 Pages 1 and 2 ment of Health SUROCK LOPPAINE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify) ENTOMB DULANEY BALTIMORE, MANYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JESEPH N. ZANNING TR. FH. 263 S. CONKLING St. BALTIMORE, MD 21224 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dever **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9□Unknown 9 Unknown has been signed by le 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2₩ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year) | SEP 2 8 200

32. Registrar's Signature

			State of Maryland /	-			Mental Hy	giene		
			1 - State Registrar	Cer	tificate of D	Peath		Reg. No.2 0	07	31246
	Physici		1. Decedent's Name (First, Middle, Last) Regina Sch	ultz			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Deat		4c. County	- /	
			FRANKlin SQUARE HOSPITAL		Rosedo				rimor	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2015 7. Age (In yrs. last 87	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Date of Date of Birt)	y, Year) 11920	Countr	ace (State or Foreign y) LAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To		nation				10	d. Inside City Limits
	laryla shov	or		SEDA					10	1 □Yes 2XNo
	the N 28a-f notiffe	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Countr	ry?
	3a or	J D	8017 CAMHILL DRIVE		21237	,		USA		
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No to Rican, etc.)	. 14. Rac	e - America	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Year or Dates:		I□Yes 2☐No	Specify:		Specify	WHI	TE
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show marked other the Medical Examiner must be notified at	ted		6a. Deced	lent's Usual Occupa kind of work done di	tion	rkina	16b. Kind of Bu	ısiness/Indu	ıstry
2	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	MEMAKER	aring most or wo	rking	OWN E	IOME	
	Hygie Hygie ther th		8 0			18. Mother's Na	me (First, Middle,			
Maryland	lld be lental ked o ic eve	To Be	JOHN DANIELS			MICHA		UNK		
ary	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	g Address (Street a	nd Number or R	ural Route Numb	er, City or Town,	State, Zip (Code)
	1 and 2 Health em 27 I		REGINA PHILLIPS / DAUGHTER		21 CAMHI	LL DR		<u>-</u>		
altimore,	Pages 1 a nent of Hea int: If item iry or othe		1 Burial 2X Cremation 3 Removal from State	etery, crer	sition (Name of matory or other place		Date 0 / 0.7	20c. Location -	•	
븚	permit. Pag Department Important: I any Injury c		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		REMATORY		8/07 ACH/ROS	BALTIM		RAL HOME
B	permit. Departr Importa any Inju				211 CHES					
			23a. Part1. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician	Il Examiner	Immediate Cause (Final disease or conditiona. Sep515							Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence)							
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8760,	ficate be executed physician and s the burial-transit									
687	icate b physic	dical	d							
X	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		75.			23d. Da	te of deliver	у
Vital Records, P.O. Box	w requires that the death oertifit been signed by the attending I should be detached for use as	Completed by Physician/Me	in the past 12 menths? 1 ☐ Yes 2 ☐ No 1 ☐ He past 12 menths? 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			Mo	onth [Day Year
<u>Р</u>	hat the	Phy	Part II. Other significant conditions contributing to death but not resulting	na in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use cont	ribute to the	e cause of death?
Ġs,	puires f	d by	chronic obstructive Pulm	-		ease	1 🗆	Yes 2 No	3 🗌 Proba	ably 4 Unknown
S	aw red s beer 2 shou	olete	Atrial Fibrillation		•		24a. Was		Were autop	sy findings available
<u> </u>	Physician: The lav this certificate has al director, page 2	omo					autoj perfo 1∐ Yes	rmed2	prior to com death? 1 ∐Yes = 2	npletion of cause of 2 No
/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?		Other		ath (Check only o	one)		
o.	Physic rthis ral dir	<u>۲</u>		Outpatier b. Time of		4 🗆 Nulsing	Home 5 ☐ Resi	dence 6 □Oth)
o	Attending Ph or death. rector; After th by the funeral	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work	?ື ∕es 2∐No	200. D0301.00	now injury occur	.00	
Division or	r Atter er dea rector	27. Manner of Death Action City or Town, State, City or Town, State,							er or Rural	Route Number,
	oital or urs aftu eral Di			1				()		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	age, death and/or in	n occurred at the tim vestigation, in my op	oinion, death occ	e, and due to the curred at the time,	date and place,	and due to	the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier.		29c. License	number		29d. Date signe	d (Month, E	Day, Year)
)	- 2 - 0		I fummet Dupta		RES	0000	00	Septer	nber	26,2007
	8		30. Name and address of person who completed cause of death (Item 23	Ba) (Type,	Print)	2.0				
	Sta	to_	31. Date filed (Month, Day, Year) #2. Registrar's Signature	N Sc	JUGRE	rkive	Paclin	none	nd a	21631
	Registr		30. Name and address of person who completed cause of death (Item 23 DR SUMMIT GUOTA 9000 FRANKLI 31. Date filed (Month, Day, Year) SEP 2 8 2007	MOON	Che P					

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Leo Edward Sands, Sr.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

XXM 2□ F

Physician

/Medical

Examiner

Funeral

State of Maryl	and / Depa	artment	of Health and	Me	ntal Hy	/gien	е					
	Cei	rtificate	of Death			Reg. No	.20	07	3	1247		
s, Sr.					Date of D Month ept		, 20	0 ^{Year}	3. Tin	ne of Death		
reet and number)		4b. City, To	own, or Location of De	ath		40	c. Count	y of Deat	h			
al Center		Randa	Randallstown				alti	more				
M 2□F 7. Age (In)	rs. last birthday) Yrs.		If Under 1 Year If Under 24 Hrs. 8. Date of Birth					9. Birthplace (State or Foreign Country)				
10c.	City, Town or Lo	ocation							10d Insid	de City Limits		
	Randalls									Yes 2∕⊠ No		
		10f. Zip C	ode			10g. C	itizen of	What Co	untry?			
		2113						State				
2. Was Decedent Ever i Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WW		Was Decede If Yes, specif 1 ☐ Yes 2[nt of Hispanic Origin? y Cuban, Mexican, Pu XX o <i>Sp</i> ec <i>ify:</i>	(Specif erto Ric	y Yes or N can, etc.)	0-		ck, Whit	rican India e, etc. nite	π,		
ation completed)	16a. Dece	dent's Usual	Occupation	vorkina		16b. l	Kind of E	Business/	Industry			
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	TITCVII	LOT INC.	18. Mother's N	ame (F	irst, Middle	e, Maide	n Surna	me)				
			Mary S	pit	zer							
e. Print)			Street and Number or						. ,			
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moval from State	b. Place of Dispo cemetery, cre ke View		ial Park 9,	Dati /27 /					Town, Stat	e		
7	P: 11	2. Name and	Address of Facility	ral	Uomo	- Sec	Cro	mata				
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ic. If yes, outcome pf pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	etal death 3	⊒Ectopic pre ⊒Other (spe						ate of del	livery Day	Year		
ributing to death but not	resulting in the u	nderlying car	re given in Part I		23e Did	tobacco	USE COL	atribute to	the cause	of death?		
and the death but not	resulting in the u	inderlying cat	ise given in rait i,	_			2□ No			4X Unknown		
ency						s an opsy formed?		. Were au prior to death?		ings available of cause of		
			26. Place of D	eath (0					_45,10			
ospital:	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home	5 ☐ Res	sidence	6 □01	ther (Spe	cify)			
28a. Date of Injury (Month, Day Yea	r) 28b. Time o	of 28	c. Injury at Work? 1 Yes 2 No	280	d. Describe	how inj	ury occu	irred				
28e. Place of injury - A building, etc. (Sp.	t home, farm, st ecify)	reet, factory,	office	281	f. Location City or To	(Street a own, Sta	and Num te)	ber or R	ural Route	Number,		
iclan: To the best of my										180(8)		

2007

State Registrar 31. Date filed (Month, Day, Year)

SEP 28

AMASWAMY I CANGARAMAN Northwest Hospital 5401 Old Court Rd. Randallstow,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b, perfft, \$72,10/4/07; WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2007 31248 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** CO 130 AM 4a. Facility Name (If not institution, give street and number) 5 eptember /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinci Hospital

5. Social Security Number Baltimore 0 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Months 213-14-2657 Usual Residence of Decedent Director maryland 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County show 1 □Yes 2 No items 23a or 28a-f shiner must be notified Director Anne Arunde Glen Burnie Street and Number 10f. Zip Code 10g. Citizen of What Country? 2126 Funeral 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 9 Specify: Specify. Completed by Black 3 Widowed 4 □ Divorced "natural", 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Thone mail Clerth permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg, Important: if item 27 is marked any injury or other *** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပို nudolph levi Lang Elaine Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5617 Belleville
Ave Paltimore MD 21207 erome F. Braun, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Baltimer , mo 4 □ Donation 5 □ Other (Specify) codla 09.27.07 22. Name and Address of Facility Vaughn C 21. Signature of Funeral Service Licenses Greene funras servica Naugh C Deene 8728 Liberty Ma Menda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. The mendallstown mo 21132 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MASSIVE CEREBROVASCULAR INFARCTION day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours, the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral o determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lanataun, MD RES - 000 Destember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUN Hospital 31. Date filed (Month, Day, Year) SEP 2 32. Registrar's Signature State 8 Registrar

DHMH 17 Rev 1/2001

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			For State	State of Marylan							2121.0	
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Centiti	icate of l	Jeath	2. Date of Dea		2007	3 2 4 9	
	hysicia /Medic	_	Theda	Ε.	Stauf			Sept	25,	2007	12:15 м	
E	Examin	er	4a. Facility Name (If not institution, give s Fort Wasningto	n Rehab Ce			Location of Death			County of Death ince G	eorge's	
	ineral rector		5. Social Security Number 6. Sex 172 18 0714 1	7. Age (In yrs. 88		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 5	Year)	9. Birth Cot 919 Pe	place (State or Foreign intry) Il Il	
yland	MOI.		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	on					10d. Inside City Limits	
e Mar	Ba-f o	ctor	Maryland Prince	George's	Temp1e	Hills					1 ☐ Yes 2X☐XNo	
h with th	s 23a or 28a-f ehow wat be notified at	al Dire	10e. Street and Number 5919 John Adams	Drive	1	of, Zip Code 20748	3			ten of What Cou ted St	-	
ep de	al', or items 2 executiver cau	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveA A Year or Dates:		Decedent of His, specify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White Specify: Wh		
2-C	natura dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent' (Give kind	s Usual Occupa	ation during most of wor	king	16b. Kir	nd of Business/I		
ZTZTS-0036 d within 72 hours af giene.	then the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	House)		Own	Home		
	d othe event,	Be	17. Father's Name (First, Middle, Last) Mervin	Miller				ne <i>(First, Middl</i> e, rrie (Maiden .	,		
Maryland d 2 should be file th and Mental Hy	marke matic	ဥ	19a. Informant's Name/Relationship (Typ		19h Mailing Ad	ddrass /Straat					ip Code)20748	
C =	item 27 is mar other treumat		Francis Stauf				dams Dr					
More Pages 1 a	±≒≒		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	movar nom State	Place of Disposition cemetery, cremator	n (Name of ry or other plac	e) Oct 3	,Date 2007	20c. Lo	cation - City or 1	Town, State	
Saltimore, bermit. Pages 1 a Department of Hea	ortant: injury c		4 Donation 5 Other (Specify) 21. Signature 5 oner Sept. License	M M	t. Zion 22. Na	Luth:	ran Cem	etery	Yor	k, PA	nc 6633 01	
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/Me			Approximate Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
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.O. BOX 68 the death certifica	been signed by the ettending ph should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 ☐ Ecto	opic pregnancy ner (specify)			2	3d. Date of deli Month	very Day Year	
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로 를 <u></u>	has 18 2	Completed						24a. Was autop perior 1 Yes	sy med?	prior to death?	lopsy findings available ompletion of cause of	
OT VITAL	ertific sctor.	Be	25. Was case referred to medical examiner?					th (Check only o	_ 			
- ²	a Pi	2	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOA Othe	4 Districting in	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
VISION O	After	ation	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No						Bookings from injury seconds			
DIVISION To the Hospitel or Attention 24 hours after death	al Director: ed in by the	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospi 24 hou	• Funers! Dir	Medical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examin	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occ tion and/or investi	curred at the tim gation, in my or	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
To the	сопрі	Me	29b. Signature and title of certifier			29c. License				signed (Month		
			> William Onla	meny		D3	206		Sin	Jenbu 2	1207	
	5		30. Name and address of person who cor	NHER MD	n 23a) (Typa, Print	ingetm	Rush 1	Int was	in 142	iton p	18mg/md	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 8 2007	32. Registrar's Signa	iture Sparke	9				, , , , , , , , , , , , , , , , , , , ,		

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

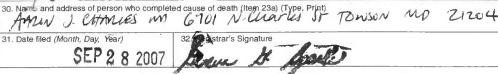
Registrar

Charles

Sprinkle,

State Registrar

31. Date filed (Month, Day, Year)



058303

September 27 2007

			1 - For State Registrar	State of Maryland			of Health of Death			iene 00	7	31252	
	Physici	40	1. Decedent's Name (First, Middle, Last)					2. Date of Deal		ear r D	3. Time of Death 1230 A M	
H	/Medic Examin		4a (Facility Name (If not institution, give	1/		4b. City, Tov	vn, or Location	of Death		4c. County of I	Death		
	Funeral Director		5. Social Security Number 6. Se 215-24-0123	T. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	Min.	8. Date of Birth (Month, Day) Jan. 15	Year)	Birthplac Country Texa:		
	ow III		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d	1. Inside City Limits	
:	8a-feh	ctor	7	imore				emere				1 ☐ Yes 2 📉 No	
	a or 2	Funeral Director	10e. Street and Number 2214 Lodge Farm	Road		10f. Zip Co	de L219		'	Og. Citizen of Wha			
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.			rigin? (Spec	offy Yes or No- Rican, etc.)	14. Race		n Indian,	
5-0036	be filed within /2 nouts atter death with the maryland tal Hygiene. do other then "naturel", or items 23a or 28a-f show event, "to Medical Examinations to notified at	by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐				Specify:	vinte, et	White	
512 1	ined within 72 h Hygiene. other then "natt	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual O kind of work o DO NOT use r	ccupation lone during mo etired)	st of workin	g	16b. Kind of Busin		stry	
7	Hygier ther th	Cor	8 Years 17. Father's Name (First, Middle, Last)		Hom	emaker_	18. Moth	ner's Name	(First, Middle,	Own Hoi Maiden Sumame)	me		
Maryland 21		To Be	Charles West						nnie Le				
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Mr. Cecil M. Hul				reet and Numb Farm 'R			r, City or Town, Sta e, Maryl		20de) 21219	
<u> </u>			20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ F	Removal from State	metery, crer	sition (Name on atory or other Service	of rplace)			20c. Location - Cit TOWSON	•		
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature 11 Juneral Service Licens	1	22	2. Name and A Duda-Ri	ddress of Faci uck Fun	ity neral	Home of	Dundal Maryland			
	The private search of	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	ence of):		ICTIVE	7	LMONA	,	eeps.	nterval Between Onset and Death	
ğ	death certific e attending p id for use as		in the past 12 months? 1 Yes 2 No 9 Unknown	d	death 3[ath 5[⊒Ectopic pregr ∃Other (speci	(y)			23d. Date o Month	D	ay Year	
ecords, I	fuires than signed to the details be detailed.	þ	Part II. Other significant conditions co	ntributing to death but not resul		nderlying caus (RG	e given in Part	H. 		bacco use contribu es 2□No 3[ite to the		
Heco	: Ine law requires that the cate has been signed by th page 2 should be detache	Completed	ANAEMIA						autops	performed? death?		sy lindings available pletion of cause of	
Vital	ysicien: In is certificate director, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Che									
5	ng rnys fter this ineral dir	P.	P.	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury (Month, Day Year) 28b. Time of Injury						Residence 6 Other (Specify) cribe how injury occurred		
	2 2 2 2	Certification:	2 Accident Investigation 2 3 Suicide 6 Could not be determined 4 Homicide determined				2	8I. Location (S City or Town	treet and Number (n, State)	or Rural I	Route Number,		
	vithin 24 hours at Yo the Funerel D completely filled i	Medical (29a. Certifier (Check only one)	sician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, deat on and/or in	h occurred at t vestigation, in	he time, date a my opinion, de	and place, a eath occurre	and due to the co	ause(s) and mann date and place, and	er as stat due to ti	ed. he cause(s)	
,	within 2 To the 1 complet	Me	29b. Signature and title of certifier	<u> </u>		j	icense number		ż	29d. Date signed (A	Month, Da	ay, Year)	
	'n		30 Name and address of person who c	collian of death (trans	23a) (Tuna	Print'	28595		(4/25707			
	5		TASNEEM LAK	HANI, 2835	-8m	ITH A	VE SI	VITE:	2B, P.	DAIN P	M)	21208	
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 8 200	82. Registrar's Signati	ure	also .							

			_ FOr	epartment of Health and I	
		_	- negiata	Certificate of Death	Reg. No. 2007 31253
Phys	sicia	n	1. Decedent's Name (First, Middle, Last)	CORED	2. Date of Death Month Day Year 3. Time of Death
/Mo	edica	al	TOBY 4a. Facility Name (If not institution, give street and number)	SOBER 4b. City, Town, or Location of Death	\$EPTEMBER 24 2007 8:34 A M 4c. County of Death
Exa	mine	r	HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY
Fune	ral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Direct	tor		213-42-4201 1 N 2 X F 89 Yr	s. Says Track	05/24/1918 MD
land		ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	Dr Location	10d. Inside City Limits
Mary -f sho		ģ	MD PRINCE GEORGE'S MITCHEL	LVILLE	1 □Yes 2 No
h the or 28a		<u>ir</u>	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
tth wit 23a c		<u>a</u>	2304 BERMONDSEY DRIVE	20721	U.S.A.
If e, Maryland ZIZIS-WU30 Stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at		by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give X	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	Decify Yes or No- b Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
-UUSD hours af tural; or		ed b	15 Decedent's Education 16a D	recedent's Usual Occupation	16b. Kind of Business/Industry
r 10 rin 72 rin "na Medic		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of wor ife. DO NOT use retired)	king
A with		<u></u>		MEMAKER	OWN HOME
Ind be file tal Hy d oth		Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
fiaryiand & Laryiand & Should be filed von and Mental Hygie is marked other the raumatic event. The		၉	LOUIS ADELBE 19a. Informant's Name/Relationship (Type. Print) 19b. Name/Relationship (Type. Print)		GOLDBERG real Route Number, City or Town, State, Zip Code)
Mal id 2 st idt an itt an 27 is r					-MITCHELLVILLE, MD 20721
Daltimore, M permit. Pages 1 and 5 Department of Health Important: If item 27 any Injury or other 27			20a. Method of Disposition 20b. Place of D	Disposition (Name of crematory or other place)	Date 20c. Location - City or Town, State
altimori mit. Pages partment of I portant: If ite			1 Marial 2 Cremation 3 Hemoval from State	i i	6/2007 FINKSBURG, MD
ermit. spartn	ouce.		21. Signatur, of Funy al Service Licensee	22. Name and Address of Facility	OL LEVINSON & BROS., INC.
D 20E	ō	_	4/1/		ROAD - PIKESVILLE, MD 21208
Physici	an	H	23a. Part / Enter the disease, or complications that caused the death. Do no shock for learn failure. List only one cause on each line. Immediat Cause (Final disease or condition ACUTE MYOCARDIA		c or respiratory arrest, c or respiratory arrest, Approximate Interval Between Onset and Death DAYS
/Medic Examin			resulting in death) Due to (or as a consequence of		
LAUIIIII	38-24	er	Sequentially list conditions, Due to jor as a consequence of	i:	
I de la		Examine	If any, leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events		
ate be executed hysician and the burial-transit			resulting in death) Last Due to (or as a consequence of);	
ate be ex hysician a		dical	d		
ertifica ling pt		Neg Neg	IF FEMALE:		
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.		hysician/Me	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
the de	3	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)	
requires that the een signed by the		Д.	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
cords w requires been signshould be		ed by			1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown
law re		plet			24a. Was an autopsy findings available prior to completion of cause of
The The gate h	r l	Completed			performed? death? 1 Yes 2
Sician: The law certificate has birector, page 2.8		Be	25. Was case referred to medical examiner? Hospital: Hospital:	0.4	ath (Check only one)
OF Phys	3	2	1 ☐ Yes 2 No	ALL INDISHIGI	tome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
On nding th. : Afte		tion		ury Work? M 1 ☐ Yes 2 ☐ No	
VISI Atter		ilica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ital or rs after all Dir		Certification:			
DIVISION OF VIICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.		edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.		
To th		Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	,		Day Korenbar	D 09834	SEPTEMBER 25, 2007
F	1		30. Name and address of person who completed cause of death (Item 23a) (T		AOS
10	Stat	e	BARRY ROSENBAUM 3720 FARRAGUT AVE. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	KENSINGTON, MD 208	395
Red	, stat istra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Frank P. Tana 2407 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death josedale uare timore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days Hours 1 M 2 ☐ F 215-16-0170 86 Maryland 6-29-1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Baltimore MD Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1708 Dundalk Avenue 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 21 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Public Works Supervisor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Liberatore Tana Ciara Molina 19a. Informant's Name/Relationship (Type. Print)niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 48th St. Baltimore, Maryland 21224 Lucy Marzano 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 9/29/2007 Baltimore, MD Geenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 6 263 S. Conkling St., Ball 23a. Part1. En The Include Sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. 263 S. Conkling St., Baltimore, MD 21224 Immediate Lause 4 inal disease or rondition resulting in eath) cinoma ON 01 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unseed or light) that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy . □ Live bitti 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown Month Vear in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 0 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Important: If item any injury or other once. Physician /Medical Examiner Examine

Physician

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

item 27 Is marked other than "natu other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

/Medical

nding physician and use as the burial-tran signed by the a d be detached f

Completed by Physician/Medical

Be

2

Certification:

Medical

4 Homicide

29a. Certifier

29b. Signature

Samantha

31. Date filed (Month, Day, Year)

determined

2 8 2007

and manner stated.

9000 Fran

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital or Attending Physician: The law requires that the death certificate be executed I Director: After to d in by the funera

Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral C completely filled it

> State Registrar

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 66306

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARLON J. CHANIES IM 6791 N. CHARUS ST ARON J. CHARRS IM 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 8 2007

29c. License number

Tarson no zizon

29d. Date signed (Month, Day, Year)

September 25 2007

ORIGINAL

			For State	State	of Marylar		artment of F		and M			^ 7	0.1057
	11 25 2		Registrar 1. Decedent's Name (First, Middle,	Last)			incate of i	Dealii	T	2. Date of Dea		U/	3. Time of Death
	Physici /Medic		Joseph James W	aters					S	Month EFTEMBI	ER 21,	Year 2007	06:55 MM
	Examir		4a. Facility Name (If not institution, Saint Josep	give street and nu h Medic	umber) cal Cer	nter	4b. City, Town, o	119.00	Death	on	4c. County	of Death Balt	imore
	Funeral Director		5. Social Security Number 028-03-6661	3. Sex 1 x M 2□ F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 12/25/1	Year) 918	9. Birthp Cour	olace (State or Foreign
	Ď		Usual Residence of Decedent		100 0	. T							
	show	7	10a. State 10b. County			ty, Town or Lo							0d. Inside City Limits 1 ☐ Yes 2√☐ No
	the N 28a-f notifii	rect	MD Baltim 10e. Street and Number	ore	L	uthervi	10f. Zip Code			1	0g. Citizen of \	What Cour	
	h with	al Di	406 Five Farms	Lane			21093				USA		
	ems a	Funeral Director	11. Marital Status	12. Was Dec Armed F	cedent Ever in U	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		e - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 [X] Yes If Yes, G Year or I	2 □ No live		1 ☐ Yes 2 No Specify:				w Whi		
8	2 hour atural cal Ex	ed b	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation			16b. Kind of B	usiness/In	dustry
215	thin 72 an "na Medi	Completed	(Specify only highest Elementary/Secondary (0-12)) (1-4or 5+)		kind of work done of NOT use retired			ng			
7	ed wil lyglen ner th: nt, the					Manuta	acturing			(E) + 141.11	Metal		aging
and	ntal H ed oth	To Be	17. Father's Name (First, Middle, L James Joseph Wa	,						(First, Middle, I		ne)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. And T is marked other than "natural", or items 23a or 28a-f show defect traumatic event, the Me I cal Examiner must be notified at		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Numbe	er or Rura	l Route Number	r, City or Town,	State, Zip	Code)
Š	and 2 alth a 27 is sr trat		Joseph James Wat	ers, Jr.	/Son	420 (Conway Pi	ne Ct	., S	t. Loui:	s, MO	6314	L
altimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.				sition (Name of matory or other place VICE COMPO	ration			20c. Location - Tows	City or To	
Balti	permit. Departm Importa any Inju		21. Signature of Euneral Service L	censee	udi	, 10	2. Name and Addre	ss of Facilit	Ruc Tow	k Towso	n Euner	al Ho	ome, Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the dear	th. Do not ent	er the mode of dyir	ng, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a. ACL	JTE REN	NAL FA	ILURE						Onset and Death MONTHS
	/Medical Examiner		resulting in death)		O (or as a consec		1.0						
		e.	Sequentially list conditions,	b	(or as a consec								
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	LOV	VER EXT	FREMIT	Y EMBOL	US					
Ö,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	o (or as a consec	quence of):							
8760	cate b physic the b	dical	•	d				·					
9 X C	death certific attending p	/Me	IF FEMALE:	23c. If yes, or	utcome pf pregn	ancy					23d Da	te of deliv	erv
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the bunal-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	birth 2 ☐ Feta gnant at time of a	aldeath 3□	Ectopic pregnancy Other (specify)	/				onth	Day Year
О.	res that the de signed by the a be detached f		Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use cont	tribute to t	ne cause of death?
Records,	w requires been sign should be	ed by	,							1 □ Y	es 2 No	3 ☐ Prob	pabły 4 ∐Unknown
ဝင္ပ	ne law re has bee ge 2 sho	Completed								24a. Was a	n 24b.	Were auto	psy findings available mpletion of cause of
Ě		Som								perfor	med?	death?	2 XNo
Vital	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death	(Check only or	ne)		
	Phys this	٦.	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o		4 🗀 140		ne 5 Reside			y)
o	Attending Fr death. ector: After by the funer.	tion	1 ■ Natural 5 □ Pending 2 □ Accident investiga	(Mo	nth, Day Year)	Injury	Wor	k?¨ Yes 2□		iou. Boodingo iii	on injury occur	100	
Division or	or Attend after death. Director: / in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Plac	ce of injury - At h	i nome, farm, str	eet, factory, office		2	28f. Location (S. City or Town	treet and Numb	er or Rura	al Route Number,
	pital or A	Cert											
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical		xaminer: On the			n occurred at the til vestigation, in my o						
	To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier	and ma	Tiller stateu.		29c. Licens	e number		2	9d. Date signe	d (Month,	Day, Year)
	F > F 0		Inde 4.a	elle, M	٥		D59711 Sept. 27, 2007				2007		
	10		30. Name and address of person w	' '		m 23a) (Type,	Print)				- 1		
	l		LINDA G. ADL 31. Date filed (Month, Day, Year)	100	Doeffitzaria Cian	atura.	R DRIVE	TOW	SON,	MARYL	S QNA	1204	
	Sta Registr		SEP 2	8 2007	Togotal's Sign	K A	person						

Physician /Medical Examiner

Physician

/Medical

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the M. Acai Examiner must be notified at ance.

Baltimore, Maryland 21215-0036

certificate ha After this certification funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760, arphi

	disease or condition	a Dementia										
	resulting in death)	Due to (or as a consequence of):										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilipory that initiated events	bDue to (or as a consequence of):										
dical Exa	resulting in death) Last											
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year							
<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to											
ed by	prostate	2 No 3 Probably 4 Vunknown										
Complet		24a. Was an 24b. Were a autopsy performed? performed? 1 □ Yes 2 ♥ No 1 □ Ye										
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[□ DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)							
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Work?	28d. Describe how in	njury occurred							
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	ocation (Street and Number or Rural Route Number, City or Town, State)							
Medical (nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.										
Ž	29b. Signature and title of certifier	a mo	29c. License number D 51705	29d. Date signed (Month, Day, Year) 9 - 2 7 - 0 7								

State Registrar 31. Date filed (Month

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR, Hestminster, mp 21157

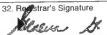
State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:15 AM 27,200 Ronald James Wright 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Elk Mil1s 45 Knob Hill Road 8. Date of Birth (Month, Day, Year) Oct. 12, 1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 13€ M 2 F Yrs. Director 1953 Tennessee 186-44-5419 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or iteme 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at Elk Mills 1 ☐ Yes 2 No Director Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Knob Hill Road United States 21920 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 in Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natt any niury or other treumatic event, the Mentalman once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local 24 Electrician 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aleen Jordan Victor C. Wright ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda R. Wright (Wife) 45 Knob Hill Road Elk Mills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 10/1/2007 Baltimore, Maryland Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Þ Dundalk, Maryland 21222 7922 Wise Ave. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or compleshock, or heart failure. List only o Immediate Cause (Final Physician disease or condition resulting in death) loni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last chem Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of P.O. Box 68760 by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the a Id be detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this of in by the funeral director ဥ 1 ☐ Yes 2 ☑ No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a completely filled 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w Ras 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1669 Slasons 31. Date filed (Month, Day, Year) 38. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Terry Eugene Boose September 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove Hospice House Westminster If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F 217-46-0371 Director 60 Jan. 29, 1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Carroll Mt. Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4808 Ridge Road 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify. 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) physical scientist cartographer/ College (1-4or 5+) Elementary/Secondary (0-12) 12 Federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Boose Evelyne J. Eichelberger ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia J. Boose/wife 4808 Ridge Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 9/26/2007 | nr. Tyrone, MD Baust Cemetery 21. Signalure of Funeral Service Licens 22. Name and Address of FacilityHartzler Funeral Home athanie (6 E. Broadway UnionBridge, MD 21791 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 200 disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760% Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 15 Kumberly A 444 wonc Drive Westminster, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar 31. Date filed (Month, Day, Year) SEP 1 7 200





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 7:50 pM Bertha Mae Brown September 9, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 1004 Rosemere Avenue Silver Spring if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 X F 87 Director 234-38-7187 January 19,1920 West Virginia Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 K No ns 23a or 28a-f sh must be notified Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 'natural", or Items 23a 1004 Rosemere Avenue 20904 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify. þ 3 ⊠ Widowed 4 □ Divorced Caucasian Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Beauty 1 Hairdresser permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dosha Emiline Holland John Smallwood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13203 Camellia Drive, Silver Spring, Maryland 20906 George C. Brown - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Arlington National Cemetery: 9/25/2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904 11800 New Hampshire Avenue, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 year Carcinoma of the Urinary Tract /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the second cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of) the attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached 9☐Unknown 9 Unknown signed by t d be detach The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Pre-existing Carcinoma Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2: autopsy performed certificate 1□ Yes 2 NO Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 To the Hospital o within 24 hours aft To the Funeral Di 1 😡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 13, 2007 D02338

6)00

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

State Registrar

Richard Delaney, M.D., 3929 Ferrara Drive, Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) 32. Resstrar's Signature SEP 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sulce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Frederick Belt Sr. September 8 2007 10:43 ^Mo 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical, Center Annapolis If Under 1 Year | If Under 24 Hrs. Anne Arundel 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months **№** 2 | F Hours 212-32-1391 73 Sept. 11 1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2√☐ No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1600 Hawkins Road 21401 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married X Married 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th 0 Master Carpenter Exxon Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Belt Mary Greenleaf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> Gertrude Belt (Wife)</u> 1600 Hawkins Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Tabor U.M. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Eurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Church Cemetery 9 22. Name and Address of Facility 9/14/07 Chesterfield, Md 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary 821 West St. Annapolis, M 821 West St. Annapolis, M shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month LING. ancea disease or condition resulting in death) Due to (or as a construence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

"natural", or

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the once.

Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Exami attending physician and for use as the burial-trar Physician/Medical signed by the a Completed by rector, page 2 Be 2 funeral Medical Certification:

The law requires that the death certificate be executed or Attending Physician: Funeral Director: itely filled in by the Hospital within 24 h To the Fu the

Division or Vital Records, P.O. Box 68760

Registrar

2 NR/Outpatient 3 DOA

1 🔲 Inpatient 28a. Date of Injury

5 ☐ Pending investigation 6 ☐ Could not be determined

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

4 Homicide

(Check only

28b. Time of (Month, Day Year)

М 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

H0052843

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

michekuille Rd, Bowie MD 20716

2 No

29d. Date signed (Month, Day, Year) -10 - 200

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sw Ab 31. Date filed (Month, Day, Year)

SEP 1 3 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary M. Burke 9/11/2007 6:32am^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1133 Sailfish Ct. Churchton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/25/1924 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 □ M 3 TXF 82 Director 089-18-3370 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notifled 1 Yes & No Director FLSarasota Sarasota 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3376 Ramblewood Dr. Funeral 34237 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 🏖 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 🛪 o White þ Specify: ₩Widowed 4 Divorced "naturai", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Draftsman Telephone Company is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Collins Grace Wartinger item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Burke Daughter 1133 Sailfish Ct. Churchton, MD 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of h Important: if ite any injury or ot 3 Removal from State Calvary Cemetery 9/15/2007 Johnson City, NY r (Specify) Hardesty FUneral Home, P.A. 21. Sign ture of Funeral Ridgely Ave. Annapolis, MD 21401 23a. Fart . Enter the dis base, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Opset and Death Im redia e Cause Fina dis ase or condition resultire in death **Physician** 1MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an has e 2 autopsy certificate ha perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ပ 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1X Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

31. Date filed (Month, Day, Year) SEP 1 3 2007

30 Theme and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

Physician/ ledical Examine			Reg. No. 2007 3 L 0						
			Month Day Year September 21, 2007 1030 hrs						
	4a. Facility Name (if not institution, give street and number) 6336 Roscroft Drive	4b. City, Town, or Location of Death Fort Washington	4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. las 215-72-7170 1 M 2 F	st birthday) If Under 1 Year If Under 24Hrs. 5 1 _{Yrs.} Months Days Hours Min.	B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington, Country) DC						
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location	10d. Inside City Limits						
Maryland 28a-f show 1 at once	Maryland Prince George's	Fort Washington	1 Yes 2X No						
the Maryland to 28a-f sh tiffed at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
with the Maryland ns 23a or 28a-f sho be notified at once aral Director		20744	USA						
215-0036 he filed within 72 hours after death with the Maryland nital Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 V No	 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Richards) 							
safter d	Widowed 4 X Divorced if Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: White						
hours after 'natural", Examiner		16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired							
5-0036 led within 72 hour bygiene other than "natu the Medical Exat Completed	- Lementary/secondary (0-12)	Flight Attendant	Private Industry						
21215-0036 Juld he filed within 72 Mental Hygiene marked other than ic event, the Medical To Be Comple	17,1 action of training (1 mod, triadilo, 2001)		rirst, Middle, Maiden Surname)						
2121: Ild he fil Mental I narked event,		Mary Elle 19b. Mailing Address (Street and Number or Rur	en Cameron						
Tore, MD 2121 signs I and 2 should he fill not of Health and Mental I at: If item 27 is marked other transmatic event,	Robert Boyd/Brother		Laytonsville, MD 20882						
e, N i and i Health item		ace of Disposition (Name of cemetery, ematory or other place) Sept	Date 23 20c. Location - City or Town, State						
aitimore, mit Pages i an partment of He pportant: If ite	Dullai 2 Voiettiation 3 Removal Iloni State		007 Alexandria, Virginia						
Baitimore, MD 2 permit Pages; and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumaric	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins I	Funeral Home Inc. , W, Silver Spring, MD 20901						
Physician	23a. Part I. Enter the disease, or comblications that caused the death. I								
/Medical *xaminer	failure. List only one cause on each line. Immediate Cause (Final disease Atherosclerotic	cardiovascular disease	Death						
ar Administra	or condition resulting in death) Due to (or as a consequence of)								
Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	:							
1	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
be exectician a sician a sicia	XUNPENDED AMENDED #23a,27,perME,g	873, 11/6/07 TT							
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical Fx	IF FEMALE: 23c. If yes, outcome of pregni 23b. Was decedent pregnant in the 1 Live birth	ancy 2 Fetal death 3 Ectopic pregnance	23d. Date of delivery y Month Day Year						
OX 687(ath certifica attending pl or use as the	past 12 months? 4 Pregnant at time of dea	2							
Box he death c	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
		sulting in the underlying cause given in Facts.	1 Yes 2 ✓ No 3 Probably 4 Unknown						
Records, P.(The law requires tha ficate has been signed page 2 should be det			24a. Was an 24b. Were autopsy findings available						
of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should no To Re Compilete.			autopsy performed? prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
tal Rection: The certificate ector, page		26.Place of Death (Check on							
of Vital I ing Physician: After this certifi uneral director,	1 ✓ Yes 2 No Inpatient 2 I		Home 5 Residence 6 ✔ Other: Scene						
on of on of ath. or: After the funeral	27. Manner of Death 28a. Date of Injury (Month, Day,Year)	28b. Time of Injury 28c. Injury at Work? 2 1 Yes 2 No	8d. Describe how injury occurred						
Division tal or Attendi rs after death. al Director: /	2 Accident Pending Investigation 289 Place of Jointy - At hou		8f. Location (Street and Number or Rural Route Number, City						
Division o Bivision o Spital or Attending sours after death. neral Director: Aft filled in by the fune Contification:	3 Suicide 6 Could not be determined (Specify)	mo, tam, on our taken, taken y, one of our and g, our	or Town, State)						
V 0 - = >	29a Centrer	e, death occurred at the time, date and place, and di	ue to the cause(s) and manner as stated.						
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner:On the basis of examination an and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
iL 2	Mossis The Mario	O.C.M.E. September 22, 2007							
	30. Name and address of person who completed cause of death (Item:								
	Margarita Korell MD. Assistant Medical Examine	er 111 Penn Street, Baltimore, MD 21	1201						
Stat Registra		& Spection							

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 11, 2007 8:00 Robert Dayton Broadwater /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett Goodwill Mennonite Home Grantsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Days Hours 1**⋈** M 2□ F 71 Maryland Jan. 5, 1936 Director 218-34-4514 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XNo Director Grantsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 USA 1760 Bear Hill Rd. Funeral filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 Widowed 4 Divorced White Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 is marked other t Jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Rounds Carl Broadwater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1760 Bear Hill Rd., Grantsville, MD Teresa E. Broadwater/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or once, Sept. 14, 2007 Bittinger, MD Bittinger Cemetery 21. Signatur of Fundral Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the diseas ease, or complications that caused the death. Do not a ke. List only one cause on each line. Approximate Interval Between Onset and Death ter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical ue to (or as a consequence of): Examiner avanced Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Theimer burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an page 2 s autopsy perform 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a, Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier laether 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Box 265, Grantsville, MD P.O.

DHMH 17 Rev 1/2001

State Registrar Sabahat Nawab, M.D.,
31. Date filed (Month, Day, Year)
SEP 1 7 200

7-07305 Connor Andrew Brod	Please Type or Print in Black Inde	elible Ink. Ensure All Copie ment of Health and Mental Hy	s <mark>Are Legible</mark> /giene	2007 3126						
·		icate of Death	Reg. No. 2. Date of Death	3. Time of Death						
Medical Examiner	Connor Andrew Brock Carmichael		Month Day September 18,	2007 2303 hrs						
(4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		. County of Death Anne Arundel						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last t		_	DD/YYYY) 9. Birthplace (State or Foreign						
Director	214-79-1427 1 XM 2 F	Yrs. 3 Days Hours Min	06/11/200							
		wn or Location		10d. Inside City Limits 1 Yes 2 X No						
viaryland 28a-f. show d at once.	Maryland Anne Arundel Croft	On 10f. Zip Code	10a. Citi	izen of What Country?						
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intent of Health and Mental Hygiene hat "latural", or items 23a or 28a-f sho per other transmatic eyent, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 1500 Rochester Court	21114		ted States						
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r death or iten Fune	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No			_{Specify:} White						
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21215-0036 und be filed within 7 Nothall Hygiene. marked other than te eyent, the Medical To Be Comple	17. Father's Name (First, Middle, Last) Andrew Scott Carmichael		ey Marie Hutteman							
LD 21215-0036 should be filed within 72 hours and Mental Hygiene. 7 is marked other than "natural natic event, the Medical Example To Be Completed by	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or								
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		1500 Rochester Court,		Maryland 21114 Location - City or Town, State						
imore, MI Pages 1 and 2. nent of Health a ant: If item 27 or other traum	1 X Burial 2 Cremation 3 Removal from State cre	matory or other place)		. D. M 1 1						
Baltimore, permit: Pages La Department of He Important: If ite	4 Donation 5 Other Specify, Our I	ady of Sorrows Church 09/	/21/200/TWe orge P. Kal	as Funeral Home						
Ba perm Depa Impu	(Hotom)	2973 Solomons Isla	and Rd.,Edg	gewater, MD 21037						
Physician	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	115	or respiratory arrest, sh	nock, or heart Approximate Interval Between Onset and Death						
/ /Medical caminer	Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplained Due to (or as a consequence of):	death in infancy	-							
	Sequentially list conditions, b.									
iner	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):	1 1 14 11 1								
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ox 68760, auth certificate be exc attending physician or use as the burial - sician/Medics	IF FEMALE: 23c. If yes, outcome of pregna	incy 2 Estaria propi		3d. Date of delivery Month Day Year						
certiff	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of deat	2 Fetal death 3 Ectopic preging 5 Other (Specify)	laricy	World Day						
). Boy the death by the att iched for Physi	1 Yes 2 No 9 Unknown g Unknown	If a in the underlying gauge given in Part I	23e Did tohaco	to use contribute to the cause of death?						
, P.O. Box 68760, res that the death certificate be signed by the attending physic be detached for use as the bur d by Physician/Mec	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.		✔ No 3 Probably 4 Unknown						
Records, The law requires freate has been sig , page 2 should be Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Division of Vital Records, tal or Attending Physician: The law require as therefore the above the law required by the funeral director, page 2 should be entitication: To Be Completed entification: To Be Completed			performed							
Vital Recysician: The last certificate director, page	25. Was case referred to medical	26.Place of Death (Chec	k only one)							
F Vital Physician: This certial director	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V E		sing Home 5 Resi	dence 6 Other:						
n of Virding Physical After this funeral dir	1 Natural (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	unk	njury occurred						
Division of tall or Attending are after death. The Director: After the function by the function: After the function of the fu	2 Accident Investigation 28e. Place of Injury - At hor	Fnd 10:00 pm res 2 km	28f. Location (Stree	at and Number or Rural Route Number, City						
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8 4 5 5	29a. Certifier 1 Certifying Physician: To the best of my knowledge	Promidte 1 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only Che								
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	and manner stated.								
	Det & ha fall nin	O.C.M.E.	S	eptember 20, 2007						
	0. Name and address of person who completed cause of death (Item 23a)									
	Tasha Greenberg MD. Assistant Medical Examin		VID 21201							
State Registra		Aprile .								
		-								

OCME

			For State	State of Ma	aryland /					and M	ental Hy	gien	e		
			Registrar 1. Decedent's Name (First, Middle, La	aet)		Cer	tificate	OTL	eatn		2. Date of Dea	Reg. N	2007	3	268
	Physicia /Medic	- 1	NICI L.	DUVALL							Month SEPT.	D	y Year L2 2007	5:	55P M
	Examin		4a. Facility Name (If not institution, gi	-			4b. City, T			f Death		4	County of Death		
	Funeral	Si.	SUBURBAN HOSPI 5. Social Security Number 6.		e (In yrs. last i	birthday)	If Under	BETH! Year	ESDA If Under 2	24 Hrs.	8. Date of Birt	MONTGOMERY 9. Birthplace (State or Fore			te or Foreian
	Funeral Director		579-24-3809	1□M 2 X F	81	Yrs.	Months	Days	Hours	Min.	Jan. 2	y, Yea <i>i</i> 25 1	926 Wash	intry) `	
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation	_						10d. Inside	City Limits
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	th the or 28a	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Cou	•	
	s 23a		3310 Leisure Wor		#1002		Van Daard		209		-16. 16	United States 14. Race - American Indian,			
920	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		11	vas Decede Yes, speci	ify Cubai	spanic Oni n, Mexicar Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		Black, White, etc. Specify: White		
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	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Robin D. Johnson	/ Daughte:			Wayı		e Dr.		ntgomen		/illage,		
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Baltimore,	- 두 약 글	4 Donation 5 Other (Specify) Laytonsville Cem. 9/21/07 Laytonsv 21. Signature or Funeral Service Utensee 22. Name and Address of Facility Muriel H. Barber Funeral Home									itte,	Ma.			
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		E (1)	shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTRODUCTION)											Approxii Interval Onset a	mate Between nd Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as											
B	Examiner				ROPERI'	•	L HEN	4MORI	HAGE					36 H	IOURS
	sit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequent	iones off:										
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequenc	ce of):									
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Ψ	ertifica ling ph e as th	00 1	IF FEMALE:	00-1/											
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3⊑	Ectopic pre Other (spe						23d. Date of deli Month	very Day	Year
Records, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions CORONARY HEAF		ut not resultin	ıg in the ur	nderlying ca	ause give	en in Part I	,			use contribute to		of death? ⊠ Unknown
eco	ne law requir has been si ge 2 should	Completed	CARDIOMYOPATH	ĭΥ							24a. Was	an	24b. Were au	topsy findir	ngs available of cause of
E E		Com	RECURRENT PLE	URAL EFFUS	ION						perfo 1∐ Yes	rmed?	death?	_	
Viital	slclan: Th certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 XInpatie		Outpation	t 3□ DO	Othe	ar-		(Check only o		a 🗆 0 11 12 12		
10 L	Attending Physician: r death. ector: After this certific. by the funeral director,	n: To	27. Manner of Death	28a. Date of Inju (Month, Da	iry 28	Bb. Time of Injury		8c. Injury Work			me 5 ☐ Resi 28d. Describe		6 ☐Other (Specially occurred	orry)	
sior	tendir eath. tor: Af the fur	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on			М	10	Yes 2						
Division or	l or At after d Direct	Certification:	4 Homicide determine	d 28e. Place of inju	ury - At home c. <i>(Specify)</i>	e, tarm, stre	eet, factory	, office		1	28f. Location (City or To		and Number or Ru ite)	ral Route I	Vumber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical C		Physician: To the best aminer: On the basis o and making st	f examination										se(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	100	101.	2 0	290	. License	e number	-1-		29d. [Date signed (Monti	h, Day, Yea	ur)
)	5) January	- 1/14	leer	1	1	1	-0)	W	2	SI	EPTEMBER	13, 2	2007
_	42		30. Name and address of perso wh BARRY J. LEVIN,	M.D. 1	0215 F	ERNWO		OAD,	SUIT	E 40	5, BETH	IESI	DA, MD.	20817	,
	Sta Regist		31. Date filed (Mong Eap. Yaar)	2007 32. Figistr	ar's Signature	k A	porte	•							

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Davall, NICIL 9112107 5:55 P.M

			1 - For State Registrar	State of Maryl		artment of F <i>rtificate of</i>		, ,	iene eg. No.	
		7	Decedent's Name (First, Middle, Last)					2. Date of Dea	200	3. Time of Path
	Physici /Medic		VIRGINIA	М	DEWIT	r		SEPTEMB1	ER 11 20	07 8:25 A ^M
	Examir	er	4a. Facility Name (If not institution, give s FREDERICK MEMOR		L	4b. City, Town, o	r Location of Deat CK	h	4c. County of E FREDE	
	Funeral Director		192-22-3111	M 2 X F 7. Age (In)	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. 1929 Pe	Birthplace (State or Foreign Country) nnsylvania
	e Maryland a-f show iifled at	ctor	Usual Residence of Decedent 10a. State Maryland Tredericl		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	with the	Director	10e. Street and Number 5955 Quinn Orchar	d Rd		10f. Zip Code 21704		1	Og. Citizen of What	*
2-003p	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral		2. Was Decedent Ever i Armed Forces? 1 ∐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - A	merican Indian, Vhite, etc.
1212-0	- : 2	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired memaker	oation during most of wo d)	rking	16b. Kind of Busine	
שב	filed I Hyg other	BeCc	17. Father's Name (First, Middle, Last)	1101	18. Mother's Name (First, Middle			own home le, Maiden Surname)		
ylan	2 should be and Menta is marked aumatic ev	5 E	Anthony		nicis		Miria		Barnes	
Mar	d 2 shoth and the and 7 is meter traum		19a. Informant's Name/Relationship (Type						r, City or Town, Sta	
ore, I	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Clement F. DeWitt, 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Re	20		rierly Consistion (Name of matory or other place			20c. Location - City	or Town, State
altimo	Pages tment of tant; If it		4 □ Donation 5 □ Other (Specify)	A		n Nationa				, Virginia
מ	permit. Pages Department of Important; If it any Injury or o		21. Signature of Funeral Service License	Elerso					uneral Ho ederick,	
	Physician /Medical Examiner		23a. Part 1. Exper the disease, or complication of the control of		405 H VE	ter the mode of dyli			est,	Approximate Interval Between Onset and Death
20/00,	w requires that the death certificate be executed feen signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con						
O. Box o	the death certificy the attending posterior	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome pf pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
ecords, P	equires that en signed by	by	Part II. Other significant conditions con	•		, 0	ven in Part I.	23e. Did to 1 ☐ Y		e to the cause of death?] Probably 4 ☐Unknown
_	he la	Completed	Digbetes m Hypertertien					24a. Was a autops perfor 1 Yes	sy prior	
VILAI	lcian: certific ector,	Be	25. Was case referred to medical examiner?	ospital:	. /	ot all DOA Oth	or:	ath (Check only or		
5	Phys r this ral dir	-T	1 ☐ Yes 2 No	1 ☐ Inpatient :	2 ER/Outpatier 28b, Time o	IL SUI DOA	4 LI Nursing		ence 6 Other (Specify)
DIVISION	tending eath. tor: After the fune	cation	Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Yea	r) Injury	M 1 □	rk? Yes 2 □ No			
2	tal or At s after d al Direct ed in by	Certification:	4 Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, str ecify)	reet, factory, office		28f. Location (S City or Town	treet and Number o n, State)	r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical (iclan: To the best of my ler: On the basis of exar and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	,		29c. Licens		- 1	9d. Date signed (M	
1	1.1		His His	en N = 5	habr	20	57643		7.12-05	1 .

State Registrar

DHMH 17 Rev 1/2001

Fordonick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Murtle 12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year 6. Sex 9. Birthplace (State or Foreign 88 Months 1 M 200 216-24-2633 7/21/1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2√√No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 549 Defense Highway 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc ☐ Yes 🛣 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes XX No White Specify. Specify: 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Short Frances Wilburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Licata Daughter 405 Hunters Pointe Dr. Charlotte, NC 28079 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 9/14/2007 Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part Enter the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) 1050 Due to (or as a consequence of): 48 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any Injury or other traumatic event, the Megnes.

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

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MD

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the filled in by

il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and signed by the attending physician and be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Hospital 24 hours a within 24 hours a To the Funeral C Medical the State

Examiner Physician/Medical þ Completed 25. Was case referred to medical Be Certification: To

29b. Signature and title of certifier

1 Umpatient

28a. Date of Injury (Month, Day Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an 1□ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

9.12, 2007

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2003 Medical Parkway Annapolis, MD 21401 Michael Adams, M.D.

1 | Yes 2 | 1√0

27. Manner of Death

1 Avatural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)
SEP 1 3 2007

5 Pending investigation

6 Could not be determined

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:19a **Physician** Felicia M. Fitzpatrick September 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Columbia Sunrise Assisted Living Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F 156-03-3031 87 10/10/1919 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or items 23a or 28e-1 ehow any injury or other treumatic event, If a Musical Examiner install the rolling an once. 1 ☐ Yes 2 No by Funeral Director Md. Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6500 Freetown Rd. 21044 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2½ No Specify: White Specify. 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic Mastromonica Maria Michael Natromasso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9406 Book Row Columbia, Md. 21046 Robert Fitzpatrick/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Timonium, Md. Dulaney Valley Mem. 9/20/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H.Witzke's Family F.H.Inc. 21. Signature of Epiperal Service Moensee 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OUN 20 YUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 | Fetal death 3 Ectopic pregnancy Year ģ Month Day 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 ☐ Probably 4 ☐ Unknown Breat cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2□ No 2 No 1 Tes or Attending Physician: funeral director. 25. Was case referred 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 V 10 1 ☐ Yes _2 ZNo 1 | Inpatient 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and Little C f death (Item 23a) (Type, Print) 30. Name and address of person who completed o KNOU 450 31. Date filed (Month, Day, Year) State 2007 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Jean Friend SEPTEMBER 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND 8. Date of Birth (Month, Day, May 21, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Director 217-38-3805 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dic- Examiner must be notified at MD Garrett Friendsville Director 10e. Street and Number 10f. Zip Code 1392 Noah Frazee Road 21531 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Ith and Mental Hygie 27 is marked other i r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank A. Broda Leona S. Schultz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health important: if item 27 any injury or other tr. once. Jimmie D. Friend/husband 1392 Noah Frazee Rd., Friendsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 16, 2007 | Davidsville, PA Country Side Crem 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 179 Miller St., Grantsville, MD Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of) Examiner OBESITY-HYPOVENTILATION SYNDROM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequen Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 4☐Pregnant at time of death 9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectopic pre			23d. Date of delivery Month Day	Year
Part II. Other significant conditions of CHRONIC OBSTRUCT			ause given in Part I.	23e. Did tobacc	o use contribute to the cause of d	eath? Jnknown
				24a. Was an autopsy performed?		available ause of
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 Yes 2 No	Hospital: 1 npatient 2	ER/Outpatient 3 DO	A Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory	, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Num ate)	ber,
29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	at the time, date and plac in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s	;)
29b. Signature and title of certifier	2 H ma	29c.	License number		Date signed (Month, Day, Year)	
30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)				
900 Seton	Or Cam	berland N	IN 21502			
31. Date filed (Month, Day, Year) SEP 1 7 2	32. Fegistrar's Signa					
		ORIGINAL				

Day

4c. County of Death

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

Specify:

Own Home

14. Race - American Indian Black, White, etc.

white

ALLEGANY

15:55 M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

7DAYS

YEARS

1 ☐ Yes 2 ☑ No

Maryland

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, been signed by the should be detached s certificate has t lirector, page 2 s To the Hospital or Attending Physician: director, Director: After this I in by the funeral di within 24 hours a To the Funeral I

Completed by

Be

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Certification:

Medical

State

Registrar

Division or Vital Records, P.O. Box 68760,

Examiner signed by the attending physician and d be detached for use as the burial-transit the death certificate be executed certificate has been sirector, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

purmit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Examiner must be nonce.

Physician

/Medical

Examine

Physician/Medical

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Completed

Be

Certification:

29a. Certifier

Baltimore, Maryland 21215-0036

Funeral Directo

ρ

Completed

Medical State

Registrar

29b. Signature and title of cartifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack R. Lichtenstein, 207 Ridgely Avenue, Annapolis, Maryland21401 31. Date filed (Month, L P 1 3 2007

. Registrar's Signature

and manner stated.

	1- For State Registrar		Cer	tificate of	Death		Reg	. No. 20L	7 3127
Physician/ al Examiner			O				2. Date of Death Month [September	Day Year	3. Time of Death 0155 hrs
ai Lammei	4a. Facility Name (if not	Rochelle D.			b. City, Town, or L	ocation of Death	September	4c. County of Deat	
	2661 Husk Pla		. *	11 A. I. B	Waldorf		- I	Charles	and the second
Funeral	5. Social Security Numb	per 6. Sex	7. Age (In yrs. la		If Under 1 Year			(MM/DD/YYYY) 9. Bi	ian
Director	218-41-2112	1M	2X F	28 yrs.	Months Days	Hours Min.	February	21, 1979	ountry)Maryland
any.	Usual Residence of Dec 10a. State 10b	County	10c. City,	Town or Locati	on				10d. Inside City Limits
* ·	1 Mores 7 and 1 and	Charles		V	waldorf .	i de	. K		1 XYes 2 No
he Matyland t or 28a-f show filed at once. Director	10e. Street and Number	regarda de la composición del composición de la			10f: Zip Code	nácho	A # .74 . 10g	. Citizen of What Cor	untry?
3a er outfree				to graph of	daga af	20602	X 0. 4	JU.S.A.	200 M. Paper 60
72 hours after death with the Maryland In "natural", or items 23a or 28a-f she al Examiner must be notified at once leted by Funeral Director	11. Marital Status 1 Never Married		Was Decedent Ever in U. Armed Forces?	S. 13. Wa	s Decedent of Hisp es, specify Cuban,	oanic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
fter des ft. or i er mu / Fu	3 Midowod	4 Divorced If Ye	Yes . 2 X No	1	Yes 2 X No	specify:	Mi	Specify: P	Black
atural" xamine		4 Or D	ghest grade completed)		t's Usual Occupatiost of working life.			16b. Kind of Business	/industry
	Elementary/Seconda		College (1-4 or 5+)	· ·	cic Engine		eu)	Housekee	ping
filed within 7/ I Hygiene. d other than the Medical	12th grad 17. Father's Name (Firs		<u> </u>	· Baile	0		(First, Middle, Ma		<u> </u>
Mental Hy marked of event, th	of an their window ex-	Joseph L. I	Dames ·				Sheila C	and the second	e promounts =
hould be find Mental is marked tite event,				31	, , , , , , , ,		Rural Route Numb	er, City or Town, Sta	
2 sl b ar 27 27 ma	Mr. William		-Lusband)	2661 I	Lisk Place.	Apt. #20	3 Waldorf,	Maryland 2	0602
ges I and of Healt If item ther trau	the same of the sa	Cremation 3 F	790						tsville, Maryla
g = F	4 Donation 5	Other Specify:	u.	•	Name and Address			eral Home, I	
permiti Departr Import injury	At C	Indo,	esas).			1.4	shineton.	D.C. 20019	
ysician	23a Part I. Enter the di	sease, or complicati ne cause on each li	ons that caused the death	. Do not enter the	ne mode of dying,	such as cardiac c	r respiratory arres	st, shock, or heart	Approximate Interval
Medical caminer	Immediate Cause (Fina	disease a. C	ocaine intoxica						Death
	or condition resulting in	h	to (or as a consequence o	f);		an s			
miner	Sequentially list condition if any, leading to immediate cause. Enter Underlying	diate Due	to (or as a consequence o	f):		1 11=11		Escape V	(m.
1 10	I amount manufalor in don	initiated C	to (or as a consequence o	ıf):	_				
and transit	ì .	d							
e be execute ysician and burial - tran	X UNPENDED	An	#23a,27,28a-f,	perME, g	872, 10/1/0)7 TT	4 1541		
iffcate ng phy us the t	IF FEMALE: 23b. Was decedent pred	23	3c. If yes, outcome of preg	nancy	etal death 3	Ectopic pregna	ancy	23d. Date of delive Month	ery Day Year
leath certificate e attending phy for use as the b	past 12 months?	4	Pregnant at time of de	- 41	ther (Specify)				
by the a ached fo	Part II. Other significa		Unknown	esulting in the u	inderlying cause o	iven in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
that th	5		g to coath bathers				1 Yes	2 No 3 Pr	robably 4 🗸 Unknown
es tha						17	24a. Was a		autopsy findings available o completion of cause of
requires that been signed lould be deta		*							
te has been signe ge 2 should be de							autops perforr	ned? death?	?
nn: The faw requires th rrificate has been signe tor, page 2 should be de	25. Was case referred	to medical ,			26.Place	 of Death (Check	autops perforr 1 Yes 2	ned? death?	? .
hysician: The faw requires th this certificate has been signe I director, page 2 should be de To Be Completed by	25. Was case referred examiner?	to medical . Hospi	ital: 1 Inpatient 2	ER/Outpatient	t 3 DOA	Other Nursi	autops perform 1 Yes 2 only one)	ned? death? No 1 Residence 6 Oth	? Yes 2 No
ling Physician: The law requires th After this certificate has been signe funeral director, page 2 should be de on: To Be Completed by	25. Was case referred examiner? 1 ✓ Yes 2 27. Manner of Death	No	28a. Date of Injury (Month, Day, Year)	ER/Outpatient	DOA Injury 28c. Injur	Other Nursing at Work?	autops perforr 1 Yes 2 only one) ng Home 5 F	ned? death?	? Yes 2 No
Attending Physician: The law requires th death. ector: After this certificate has been signe by the funeral director, page 2 should be decation: To Be Completed by	25. Was case referred examiner? 1 ✓ Yes 2 27. Manner of Death	No Hospi Pending Investigation	28a. Date of Injury (Month, Day, Year) Fnd 9/18/2007	28b. Time of Fnd 1:44	DOA DOA DOA DOA DOAM 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Other Nursing at Work? Yes 2 No	autops perforr 1 ✓ Yes 2 only one) ng Home 5 ☐ F 28d Describe h unk	ned? death? No 1 ✓ Residence 6 ✓ Oth	? Yes 2 No ner: Scene
and or Attending Physician: The law requires the safter death. In Director: After this certificate has been signed in by the funeral director, page 2 should be death in by the funeral director, page 2 should be death in the funeral director.	25. Was case referred examiner? 1 ✓ Yes 2 27. Manner of Death	No Hospi	28a. Date of Injury (Month, Day, Year) Fnd 9/18/2007 28e. Place of Injury - At h	28b. Time of Fnd 1:44 ome, farm, stre	DOA DOA DOA DOA DOAM 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Other Nursing at Work? Yes 2 No	autops perforr 1 ✓ Yes 2 only one) ng Home 5 ∫ F 28d. Describe h unk 28f. Location (S	ned? death? No 1 Residence 6 Ott ow injury occurred	? Yes 2 No ner: Scene Rural Route Number, City
Hospital or Attending Physician: The law requires the 4 hours after death. Funeral Director: After this certificate has been signed ledy filled in by the funeral director, page 2 should be dealy filled in by the funeral director, page 2 should be dealy filled in by the funeral director, page 2 should be dealy filled in by the funeral director, page 2 should be dealy filled in by the funeral director, page 2 should be dealy filled in by the funeral director and filled in by the funeral director and filled by the funeral director and filled in the funeral director and fil	25. Was case referred examiner? 1 Yes 2 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homidde 29a Certifier	Pending Investigation X Could not be determined	28a. Date of Injury (Month, Day, Year) Fnd 9/18/2007 28e. Place of Injury - At h (Specify) House	Fnd 1:44 ome, farm, stre	t 3 DOA Injury 28c. Injur O am 1 et, factory, office b	Other Nursing at Work? Yes 2 Noullding, etc.	autops perforn 1 ✓ Yes 2 only one) ng Home 5 ☐ F 28d. Describe h unk 28f. Location (S or Town, St dedue to the cause	Residence 6 Ottow injury occurred treet and Number or late) P1. Apt 203	Yes 2 No ner: Scene Rural Route Number, City Waldorf, MD tated.
o the Hospital or Attending Physician: The law requires th ithin 24 hours after death. • the Funeral Director: After this certificate has been signe ampletely filled in by the funeral director, page 2 should be decided.	25. Was case referred examiner? 1 Yes 2 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homidde 29a Certifier	Pending Investigation X Could not be determined rtifying Physician: dical Examiner:On	28a. Date of Injury - At h (Specify)	Fnd 1:44 ome, farm, stre	t 3 DOA Injury 28c. Injur O am 1 et, factory, office b	Other Nursing at Work? Yes 2 Noullding, etc.	autops perforn 1 ✓ Yes 2 only one) ng Home 5 ☐ F 28d. Describe h unk 28f. Location (S or Town, St dedue to the cause	Residence 6 Ottow injury occurred treet and Number or late) P1. Apt 203	Yes 2 No ner: Scene Rural Route Number, City Waldorf, MD tated.
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To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be de	25. Was case referred examiner? 1 Yes 2 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homidde 29a Certifier	Pending Investigation X Could not be determined rtifying Physician: dical Examiner:On and	28a. Date of Injury (Month, Day, Year) Fnd 9/18/2007 28e. Place of Injury - At h (Specify) House To the best of my knowled the basis of examination a	Fnd 1:44 ome, farm, stre	t 3 DOA Injury 28c. Injur O am 1 et, factory, office b	Other Nursii y at Work? Yes 2X No uilding, etc. ate and place, and, death occurred e number	autops perforn 1 ✓ Yes 2 only one) ng Home 5 ☐ F 28d. Describe h unk 28f. Location (S or Town, St dedue to the cause	Residence 6 Ottow injury occurred treet and Number or late) P1. Apt 203 e(s) and manner as stand place, and due to	Yes 2 No ner: Scene Rural Route Number, City Waldorf, MD tated. the cause(s)
spital or Attending Physician: The law requires hours after death. nneral Director: After this certificate has been sign y filled in by the funeral director, page 2 should be Certification: To Be Completed	25. Was case referred examiner? 1 Yes 2 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier 1 Cerone) 2 Me 29b. Signature and title	Pending Investigation X Could not be determined riffying Physician: dical Examiner: On ance of certifier of person who comp	28a. Date of Injury (Month, Day, Year) Fnd 9/18/2007 28e. Place of Injury - At h (Specify) To the best of my knowled the basis of examination at manner stated.	Fnd 1:44 ome, farm, stre	Injury 28c. Injury	Other Nursii y at Work? (es 2 X No uilding, etc. ate and place, and, death occurred e number M.E.	autops perform 1 Yes 2 only one) ng Home 5 F 28d. Describe h unk 28f. Location (S or Town, St 2661 Husk d due to the cause at the time, date a	Residence 6 Ottow injury occurred treet and Number or late) P1. Apt 203 e(s) and manner as stand place, and due to	Yes 2 No ner: Scene Rural Route Number, City Waldorf, MD tated. the cause(s)

			For State Registrar	State of N	Maryland		rtment of H		Mental Hygi	ene g. N2 0	07	31275
			1. Decedent's Name (First, Middle, Last,						2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Betty Ann Evans (Glotfelt	У				Septemb	er 17	2007	4:52 A.M
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town, or		th		y of Death	
			Garrett County Me				Oakland	If Under 24 Hr		Garı		
	Funeral		5. Social Security Number 6. Set	M 25XF /./	Age (In yrs. la 81	Yrs.	If Under 1 Year Months Days	Hours Mir		Year) 1926	Coun	
١.	Director		213-24-5029 Usual Residence of Decedent		01				Platen 2	1920	Mary	land
	ylenc		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	B Mar	ctor	MD Garrett		0	akland	l					1 ☐ Yes 2¾☐ No
	한 다. 0r 28	Director	10e. Street and Number				10f. Zip Code		10	10g. Citizen of What Country?		
	ath w 23e	la	6945 Gorman Road				21550			United States		
	Reme	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13. \	Vas Decedent of Hi Yes, specify Cubai	spanic Origin? (n, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		ce - Americ ack, White,	
36	i', or	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			☐ Yes 2∏ No	Specify:		Spec	^{ty:} Whi	to
Ş	10a. State 10b. County 10c. City, Town or Location MD Garrett Oakland							6b. Kind of I				
212	n n n	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Manager										
7	d with	E	Elementary/Secondary (0-12)	Conege (1.40	1 34/	Cafe	teria Ma	nager		Pub:	lic So	hools
<u> </u>	e file e Hy t oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle, M	aiden Suma	me)	
<u> </u>	Ment Ment arked	ည	Peter Miller					Blanch	ne McKenzi	e		
a	2 sh and is m		19a. Informant's Name/Relationship (T)				,		Rural Route Number,	•	n, State, Zip	Code)
2	and lealth m 27 her ti		Kim Ours, Daughte	r	20h Bi	Annual Agency Commission	The second secon	· · · · · · · · · · · · · · · · · · ·	kland, MD		City of To	State
Baltimore, Maryland 21215-0036	t of the		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from Sta			sition (Name of natory or other place			0c. Location		
Ē	t. Pa rtmen rtent:		4 Donation 5 Other (Specify)		Gar		femorial (0aklaı)
Ra	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hyglene. Importent: if Item 27 is marked other then *neturef, or iteme 23a or 28a-f show eny highry or other traumatic event, its Medical Examinar must be notified at 90cc.		21. Signature of Funeral Service Licens **Ratherms**	on Sweitzer		22	David A.	Burdocl	k Funeral , Oakland	Home,	P.A. 21550	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ne cause on each	line.		er the mode of dying	g, such as cardi	ac or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Hevatocellular Carcinoma M									
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ience of):						
	Examiner		Sequentially list conditions,	b								
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	sa e consequ	iailea ol).						
	and and	xan	that initiated events resulting in death) Last	Due to (or a	as a consequ	ience of);					-	
8760,	cate be executed bhysicien and the burial-transit	ai										
98	ficate physics the	g		J								
XOG	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcon			I			23d. D	ate of delive	ery
ň	w requires that the death cer been signed by the attendin should be detached for use	icia	in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnant	at time of de		Ectopic pregnancy Other (specify)			N	lonth	Day Year
л О	t the by th tache	hys	9 Unknown	9□ Unknown								
	ss tha	by P	Part II. Other significant conditions co	ntributing to death	but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to th	he cause of death?
ğ	equire en si		V						1 ☐ Ye	s 258 No	3 Prob	pably 4 Unknown
Division of Vital Records,	e lawr hes be je 2 sh	pie							24a. Was an		. Were auto	psy findings available mpletion of cause of
Ĭ	The ete h	Completed							perform		death?	2 □ No
<u>=</u>	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?						eath (Check only one	2		
<u> </u>	Attending Physician: r death. sctor: After this certification the funeral director, it	은	1 ☐ Yes 2 🗷 No	lospital:		ER/Outpatier		4 🗆 1401 31119	Home 5 Reside			(y)
Ĕ	ding F	Ö	27. Manner of Death 1/□Natural 5 □ Pending	28a. Date of It (Month, I	ojury Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occi	ırred	
<u>s</u>	tend Jeath tor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	One Plans of	laivar At ha			Yes 2 □No	28f. Location (Str	not and Num	abor or Pur	al Pouto Number
\leq	or A after Direct in by	Certification;	4 ☐ Homicide determined	building,	etc. (Specify	')	eet, factory, office		City or Town		iber or ribre	ar riodig redinosi.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	edicai Ce	(Check only 2 Medical Exami	ner: On the basis	of examinat	wiedga deatt	occurred at the time vestigation, in my or	date and place	ne and due to the ca curred at the time, da	usa(s) and r	nunner as s	tated o the cause(s)
	To the h within 2 To the F complete	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. License			d. Date sign		
	7 ¥ F Ø		Paul Das	not nel	ca z	00		2615		-		
		6	30. Name and address of person who or	ompleted cause o	death (Item	23a) (Type,		A	· Da	00/1	lan	57 dm D 2155
	Sta	ر te	31. Date filed (Month, Day, Year)	32. Regi	var's Signal	ture	1 2 3 10	11010	> 31	car	1000	
	Regist		SEP 18	2007	2 Cara	100	Borolle 1					
					CACHA MAN	Sec. 2	No.					

		•	For State Registrar		State of Ma	ryland / Dep Ce	ertificate of			ene 00	7 31276
	Dhusiai		1. Decedent's Name (Firs	st, Middle, Last)					2. Date of Death Month	er 12, 2	3. Time of Death
	Physici /Medic		Thomas Rus						Septemb	4c. County of I	
	Examin	er	4a. Facility Name (If not in					or Location of Death			
		-	130 Accident			(In yrs. last birthda	Accident If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Garrett	Birthplace (State or Foreign Country)
	Funeral Director		218-48-9890	1 152	M 2□F	56 Yrs.	Months Days	Hours Min.	Month, Day,		laryland
			Usual Residence of Dece	edent							10d. Inside City Limits
	arylar show	_		. County		10c. City, Town or					1 Yes 2 □ No
	Ne Milita	ecto	MD Ga	rrett		Accide	10f. Zip Code		10	g. Citizen of Wha	at Country?
	with with the or	급	130 Acciden	.+_B;++;	ngar Pd		21520	1		USA	ŕ
	Jeath Jings	Funeral Director	11. Marital Status		12. Was Decedent 8	Ever in U.S. 13		Hispanic Origin? (Sp an, Mexican, Puerto		14. Race -	American Indian, White, etc.
9	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examirant must be calified at	골	1 Never Married	2 ☑ Marned	Armed Forces? 1 ☑ Yes 2 ☑ N	10/1970	1 ☐ Yes 2 ☑ No		riicari, etc.)	Specify:	vviitte, etc.
21215-0036	urel',	d by	3 ☐ Widowed 4 ☐ [710/13/2				16b. Kind of Busin	White
2	within 72 tiene. than "netiche Medica	Completed	(Specify on	Decedent's Edu nly highest grade	completed)	(Gir	edent's Usual Occup re kind of work done . DO NDT use retire	during most of work ad)	ing	IOD. KING OF BUSIN	less madstry
12	filed within Hygiene. other than ent, the M	mo duo	Elementary/Secondary	(0-12)	College (1-4or 5	+)	ice Tech.			Petroleu	m Co.
	other ent,	Be C	17. Father's Name (First,	Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
<u>a</u>	uld be Vental rrked o	To B	Raymond Geo	org				·	t Richte		
Maryland	2 should be and Mental is marked (19a. Informant's Name/F					t and Number or Rur			
	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hyglene. I Health and Mental Hyglene teams 23e or 28e-f show item 27 is marked other than "neture!", or items 23e or 28e-f show other traumatic event, the Medical Examinant must be rediffed at		Margaret A.		Wife			Bittinger		cident, 20c. Location - Cit	
20	Pages 1 nent of F ent: If ite ury or ot		20a. Method of Disposition 1	emation 3 🗆 P	emoval from State		position (Name of rematory or other pla	ice)			•
altimore,	_ E E E		*4 ☐ Donation 5 ☐ 21. Signature of Funeral		-	Zion Ce		sept.	15, 200°		
Ba	Departiment Departiment Departiment Departiment Department Departm		Je La	un /	Remas		P.O. Box	275, Gran	tsville,	MD 215	536
			23a. Part 1. Enter the dis shock, or heart laif	sease, or compl dre. List only or	cations that caused ne cause on each lir	the death. Do not e	nter the mode of dyi	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
E	Physician		Immediate Cause (Final disease or condition resulting in death)			cinoma	e of	the Lu	ng		6 months
	/Medical Examiner		resulting in death)	(Due to (or as	a consequence of):			7		
		ا <u>ه</u> ا	Se uentially list condition if any, leading to immediate	ate	Due to (of as	a consequence of).					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	7	•						
Ö,	ficate be executed physician and is the burial-transit	Exe	resulting in death) Last		Due to (or as	a consequence of):					
8760,	cate b physic the b	dicai			d						
× 6	certifi nding use as		IF FEMALE: 23b. Was decedent preg	nnant 2	3c. If yes, outcome					23d. Date	of delivery
.O. Box	w requires that the death certiff been signed by the attending should be detached for use as	by Physician/Me	in the past 12 month	ths?	4 Pregnant at		B □Ectopic pregnand □ Other (specify) _	Э у		Month	n Day Year
0	tt the by the tache	hys	9 Unknown		9□ Unknown				1		
S,	es tha gned be de	by F	Part II. Other significant	t conditions co	ntributing to death b	ut not resulting in the	l .		23e. Did tot		ute to the cause of death?
ord	een si	ted	Chronic	c 05	structi	re pu	mongry	lisease	/ /	1	
ě	a law has b	Completed							24a. Was a autops perforr	y prid	ere autopsy findings available or to completion of cause of ath?
al F	The icate								1 ☐ Yes	No 1	Yes 2 No
<u> </u>	siciar certif irecto	Be c	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	⊢	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpat	ient 3☐ DOA	the man	th <i>(Check on on</i> ome 5 ⊠ Reside		(Specify)
ō	Physer this eral d	n: To	27. Manner of Death		28a. Date of Inju (Month, Da		of 28c. Inju			ow injury_occurred	
<u>o</u>	ath. r: Aft	atio	2 Accident	☐ Pending investigation	(Worth, Da	y Year) Injur	M 1	Yes 2□No			
Division of Vital Records,	or Atte	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (St City or Town		or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1X	Certifying Phy	sician: To the best	of my knowledge, de	eath occurred at the tinyestication is my	time, date and place	, and due to the carred at the time.	ause(s) and mann	ner as stated. d due to the cause(s)
	the Ho in 24 the Fu	fedical	one)		and manner st	ated.		nse number			(Month, Day, Year)
	with To	Σ	29b. Signature and title	or certifier	1	MAK) Zac. Licen				
		10	4119	in the	Mens	looth (Itom 222) (T	DOI	0 4) 4)	1	epicm D	er 1-, 2007
		VA	30. Name and address of		ompleted cause of c	M N D	O ROY	247 A	cident	-MD 3	er 12,2007 21520
	Sta	-	31. Date filed (Month, D	ay, Year)		ar's Signature	<u> </u>				
	Regist	rar	35	-172	UU/	the A	Secret 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September22,₂₀₀₇ Betty Hollen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Mount Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F August11,1926 West Vir 81 Director 234-34-4917 Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show diea Examiner must be notified at 1 XYes 2 No Marion Fairmont Director West Vir. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26554 U.S.A. 2 Meadowlark Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Completed by Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Burgess Theodore Baumgartner မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6958 Inverness Court, New Market, Maryland21774
ace of Disposition (Name of Date 20c. Location - City or Town, State Terri Eckard / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-27-07 Fairmont, West Vir. 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A. > gushail 6009Harford Road Baltimore, Mary and 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final LEUKEMIA YEARS VULLE Physician disease or condition resulting in death) Due to (or as a consequence of): /Medicai Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequ	uence of):						
that initiated events resulting in death) Last	c	uence of):						
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	l death 3 ☐Ectopic			23d. Date of delivery Month Day Year			
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tol	bacco use contribute to the cause of death? es 2, ☑ No 3 ☐ Probably 4 ☐ Unknown			
				24a. Was a autops perfori	sy prior to completion of cause of med? death?			
25. Was case referred to medical examiner?			26. Place of	Death (Check only on	ne)			
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nurs	ing Home 5 Reside	ence 6 Nother (Specify) Hospic E			
27. Manner of Death 1 Mantural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
- I co - Citi 1 P Contifuing Di	nysician: To the best of my known in the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and tion, in my opinion, death	occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)			
29b. Signature and title of certifier			29c. License number	2	29d. Date signed (Month, Day, Year)			
1 Brank	- M.		DONAT	760	Cast 74 2007			

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Registrar

State

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31. Date filed (Mont Star) Year) 8

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21231

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BALTMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS

SMIDT

32 Registrar's Signature

ELARA

	1	State of Maryland / Department Certifica	nt of Health and I <i>te of Death</i>	Mental Hygien Reg. N			
		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death		
Physici /Medic	al	Evelyn Bernice Huth		September	22 2007 6:18A ^M		
Examin		ta. I acinty Ivanie (ii not institution, give out out and institution)	, Town, or Location of Death	1 4	Ic. County of Death Frederick		
		Kline Hospice House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	Mt. Airy er 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign		
Funeral Director		219-94-6380 1□ M 2 ★ 43 Yrs. Months	Days Hours Min.	(Month, Day, Yea Aug. 14, 1	1964 Maryland		
D		Usual Residence of Decedent			10d. Inside City Limits		
arylar show	۱.	Tob. County	rick		1X Yes 2 □ No		
the M 28a-f	ecto	iai y iaila	ip Code	10g. (Citizen of What Country?		
3a or	<u></u>	993 Heather Ridge Dr., Unit E			U.S.A.		
ems 2	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Dec	edent of Hispanic Origin? (S ecity Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No If Yes, Give 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	2 No Specify:		Specify: White		
hour sel Ex		16a Decedent's Us	sual Occupation	16b.	. Kind of Business/Industry		
hin 72 an "ne Medic	Completed	Flementary/Secondary (0-12) College (1-40r 5+)	work done during most of work use retired)	King	hair salon		
ad with ygiene that the true the	Con	12 beaut		ne (First, Middle, Maid			
be fill hall H	Be	17. Father's Name (First, Middle, Last)		te M. Dieu			
ore, Maryland ZIZI3-UU30 ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itiem 27 is marked other than "natural", or items 23a or 28a-f show to ther traumatic event, the Medical Examiner must be notified at	2	Ernest P. Huth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Addre			ty or Town, State, Zip Code)		
y, IMG and 2 s ealth ar n 27 is ner trau		Clifton L. Huth/brother 12 Cente		el, MD 2072			
ges 1 a t of Hea If Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	r other place)		. Location - City or Town, State		
altimore, Maryland ZIZIZID-UU3O mit. Pages 1 and 2 should be filed within 72 hours af partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Exam oxe.		4 □ Donation 5 □ Other (Specify) All County C			ykesville, MD		
Baltimo permit. Page Department of important: If any injury or once.		(athanine). Har/Eler 1180:	and Address of Facility H 2 Liberty Rd.	Liberty	town, MD 21762		
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/Medical Examiner		Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to namediate cause. Enter Underlying Cause (Disease or injury	conditions, Due to (or as a consequence of):				
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cate be exemply sician a	dical	d					
D # D #	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery		
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ds, I	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ig cause given in a are.	1 ☐ Yes	2 No 3 Probably 4 Unknown		
cord w requir been si should	Completed			24a. Was an	24b. Were autopsy findings available		
Rec	dmo			autopsy performed	prior to completion of cause of death? No 1 Yes 2 No		
or Vital Rec hysician: The law his certificate has b I director, page 2 s	Be C	25. Was case referred to medical		eath (Check only one)	Hospica		
or Vital Records, Physician: The law requires! r this certificate has been signe	5 B	Loop Time of		Home 5 Residence			
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Division or V To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral direct completely filled in by the funeral direct or After this completely filled in by the funeral direct completely filled in by	edical Cer	29a. Certifier (Check only (C	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause	se(s) and manner as stated. e and place, and due to the cause(s)		
To the I- within 24 To the I- complete	Medi	one) and manifer stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)		
,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	# 12		112410		
5		Elhamy Eskarder, MD 50/1	V71hSreat	treder	ick, MD2110]		
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 8 2007)				

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	•	pariment of r ertificate of			Reg. No.			
	Ja a		Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath C	007	3. The of Zeatt 9	
	Physicia /Medic		ROY EDWARD HE	ANEY				SEPTEM	BER 19	Year 200	7 8:49 P M	
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Death			
	%		FREDERICK MEM 5. Social Security Number 6. S		PITAL (In yrs. last birthd	FREDER:		8. Date of Birth		REDER	ICK hplace (State or Foreign	
	Funeral Director			YTH OF E	32 Yrs	Months Days	Hours Min.	Nov.27	y, Year)	Co	nsylvania	
	/land low at		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
	a-fst	ctor	Maryland Fred	erick		Freder	ick				1 XYes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Co	ountry?	
	ath w		2397 Bear D			0 W Dd	21701	anifu Van ar Na	14 8	U.S	· A . erican Indian,	
	Items Iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent En	verin 0.5.	Was Decedent of F If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	В	lack, Whit		
936	urs af al", or Exami	ρ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:1 C	943-46	1 ☐ Yes 2 No	Specify:		Sper	cify:	White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Addition and other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. De	cedent's Usual Occupive kind of work done	during most of work	king	16b. Kind of			
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Maryland		o Be	Joseph Heaney					e Teare		,		
<u>Z</u>	d 2 should th and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street			er, City or Tow	vn, State, 2	Zip Code)	
	nd 2 alth a 27 k		Frances D. Heaney	/ wife	239	7 Bear Der	Rd.	Frederi	ick, MD	217	01	
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Baltimore,	permit. Pages Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service Lice	+Sar/20		22. Name and Addres	perty Rd.	Liber	tytowr		21762	
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1	/Medical Examiner		resulting in death)	- L	consequence of):	0 4	1				hours	
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_	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6								
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rds	w requires been sign should be	ed b						1 🗆 `	Yes 2. Wind	3 □ P	robably 4 □Unknown	
or Vital Records,	law re as be	Completed						24a. Was	osy .	prior to	utopsy findings available completion of cause of	
<u>=</u>		Com							2 No	death? 1 ☐ Yes	2 □ No	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea					
0	Phys r this ral dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Lampatien		TIGHT 3 DOA	4 □ Nursing H	ome 5 Residence 128d. Describe I			ecify)	
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$\left(\frac{1}{2}\right)$	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1	nysician: To the best of miner: On the basis of and manner stat	examination and/o	eath occurred at the to r investigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and place	manner a	s stated. e to the cause(s)	
	To the Comp	ž	29b. Signature and title of certifier			29c. Licens			29d. Date sig	ned (Mon	th, Day, Year)	
	ļ		M. Raza	MD		D	66166		7	119	2007	
	10		30. Name and address of person who			Doe, Print) Core Asso	ut 4	is west	-745		I N No Mar	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	- CAS 14770	rerey 70	o wear	/ 31	1-10	conce, in x1/G	
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			1 - State of N Registrar	laryland / L	Department of F Certificate of I	ieaith and i Death	vlental Hygi Re	ene 200°	7 31280	
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
4.	/Medi	cal	ELNORA HARVEY 4a. Facility Name (If not institution, give street and number	r)	4b. City. Town, o	r Location of Death	Septembe	er 13 200 4c. County of Dea		
	Examir	ier	Holy Cross Hospital	,		Spring		Montgom		
	Funeral		1□M 2 X E	Age (In yrs. last bir	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)	
- \$4. 	Director		Usual Residence of Decedent	64	TIS.		Sept. 6,	1943 Pen	nsylvania	
	yland now at		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits	
	e Mar ta-f sh tified	ctor	Maryland Montgomery	Silve	er Spring				1 □Yes 2 👿 No	
	vith th	Directo	10e. Street and Number	0.0	10f. Zip Code		10	g. Citizen of What Co	ountry?	
	eath v	Funeral	1316 Fenwick Lane, Apt #7		20910		pecify Yes or No-	U.S.A.	erican Indian.	
036	urs after d al", or iten Examiner	by	Armed Forces 1 XXI Never Married 2 Married 1 Yes 2 E If Yes, Give Year or Dates	s? ₫ No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	Black, White Specify: B.	te, etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or		Decedent's Usual Occup (Give kind of work done life, DO NOT use retired	during most of wor	king 1	6b. Kind of Business		
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ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing Address (Street	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)	
Σ,	and 2 ealth m 27 i		Darius R. Harvey/Son		3 Sligo Ave					
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ᆵ	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li ensee	Fort L	incoln Crem		007	Brentwood,	Maryland	
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ř	The lar	ошо					autopsy perform 1 Yes 2	prior to death?	completion of cause of	
		BeC	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one			
2	Attending Physician: r death. ector: After this certifica by the funeral director, i	P	I Hospital	tient 2 ER/Ou		4 L Nursing F	reaction of the second of the	nce 6 Other (Spe	ecify)	
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	- e	Certification:	3 Suicide 6 Could not be 28e. Place of i	njury - At home, fa etc. (Specify)	rm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	lural Route Number,	
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besicand manner: On the basis and manner:	of examination an	e, death occurred at the tid d/or investigation, in my d	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
	To the withing the complete co	ž	29b. Signature and title of certifier	ı	29c. Licens			d. Date signed (Mon		
	2				D0065	069		Sept. 13,	2007	
3)4	20-		30. Name and address of person who completed cause of Sirak Hagos Lemma, MD, 15			Silver	Spring. 1	Maryland 2	20910	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Register	strar's Signature			. 0,			
	Regist		SEP 1 7 2007							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8801 AM Sara E. Haas De Otember 2007 - 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Hours Min. 56 Director 401-78-0953 Nov. 4, 1950 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Funeral Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 12706 Quarterhorse Drive 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Systems Analyst Northrop Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked ot ပ George Hovious Dixie Pendry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil Haas/ Husband 12706 Quarterhorse Drive Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory 9/12/2007 | Alexandria, VA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician O Cara /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural Μ s after death.

I Director: A
od in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and
To the Funeral Dir the Hospital 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name an ddress

31. Date filed (Month, Day, Year)

Herson who completed cause of death (Item 23a) (Type, Print) 1. Shero, MID. 575 Main Street, Suite 351, Laurel, MD. 20707 32. Resistrar's Signature SEP 1 3 2007

D 51398

			1 - State Registrar	State of		_	tificate o			іепіаі ну	/giene Reg. No		7 3	1283
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	Funeral		Social Security Number 6. 8		Age (In yrs. la	**	If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Bi	irth	9		tate or Foreign
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	ath v 23a ust	<u>ra</u>	11944 Galaxy Lan					715				U.S.		
	er de	nue	11. Marital Status	12. Was Decede Armed Force	es?	S. 13. \	Was Decedent of Yes, specify C	f Hispanic O uban, Mexica	ingin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	0-		merican India hite, etc.	an,
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	nould be filed within a Mental Hygiene. narked other than natic event, the M	ပိ	17. Father's Name (First, Middle, Last	*)		300	ial Wor		ner's Name	(First, Middle	-	n Surnama)	an kes	ources
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2	should Ind Men marker	2	Thomas E. Hawkin 19a. Informant's Name/Relationship			10h Mailie	g Address (Stre			Thomp		Taura Ota	7: 0-1:	
Maryland	d 2 sho th and I 7 Is ma trauma												e, zip code)	
	ss 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene, item 27 is marked other than "natural"; or items 23a or 28a-f show cother traumatic event, the Medical Examiner must be notified at		Renita Lawrence 20a. Method of Disposition	/ Daugnt			Galaxy sition (Name of			Le, MD		15 Location - City	or Town Str	ate .
٥	Pages ment of P ant: If its ury or of		1 X Burial 2 ☐ Cremation 3 ☐		ate C6	emetery, crer	natory or other p	place)			200. 2	coodion - Ony	or rown, or	ato
Baltimore,	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Lin	coin [Memorial Name and Add	L į	9/15	/2007	Sui	tland,	MD	Τ
Ba	permit. Pages Department of Important: If i any Injury or once.		Jusma.	19 Clust			400 Geor							
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J.	Discount of the second		shock, or heart failure. List only Immediate Cause (Final					, g, · · ·					Interv Onset	ximate al Between and Death
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	tifica ig ph as th	ledi												
Вох	eath cer attendin for use	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnar h 2 □ Fetal		Testania progna	D014				23d. Date of	delivery	
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<u> </u>		<u>ان</u>	Chronic Renal Fa	ilure						perf	formed?	deat	h? Yes 2□N	
or Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Plac	ce of Death	(Check only				
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Sio	Attending r death. ector: After	cati	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2	No					
Division	or At after d Direct in by	Certification:	4 Homicide determined	20e. Place of	injury - At hor , etc. (Specify)	me, farm, str	eet, factory, offic	ce	1	28f. Location City or To	(Street a	and Number of te)	r Rural Route	Number,
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	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1X Certifying Pl (Check only one) 2 Medical Exa	hysiclan: To the be miner: On the bas	is of examinati	vieage, deatl ion and/or in	occurred at the vestigation, in m	e time, date a ly opinion, de	and place, eath occuri	and due to the red at the time	e cause(: e, date ar	s) and manne nd place, and	r as stated. due to the ca	iuse(s)
	o the ithin ; o the omple	Mec	29b. Signature and title of certifier	and manne	stated.		29c. Lice	ense number			29d D	ate signed (M	Ionth Day V	ear)
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	10		30. Name and address of person who	completed source	of dooth As	22a) (Time		MD 12	2879		Sep	tember	10, 2	007
			oo, manto and address of person Who	completed cause	or death (Helf)	Luay (1 ype,								

State Registrar 106 Irving St., N.W.

31. Date filed (Month Day

DHMH 17 Rev 1/2001

418 South Washington, D.C. 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year 2007 Monv stember /Medical 4a. Facility Name (If hot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bul timore Maryla Medical MIVERSITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 M 2 ☐ F 038-26-5486 Director May 3, 1942 Rhode Island Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 2203 Montgomery Street 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [3] No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married SpecifyWhite 1 ☐ Yes 2 ☑ No Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Senior Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Anthony Itteilag Edna Catherine DeLellis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Montgomery Street, Silver Spring, MD 20910 Nadine Markham-Itteilag/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept Date 17, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2007 Rockville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest aus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MSDIVAT BNecks /Medical Le to (or as a consequence of): Examiner tic Shock Sequentially list conditions, it any, leaving to imposite cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Thoracic/Abdominal gastrointestinal leak resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Yes 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2) No 1 Inpatient 1 ☐ Yes 2 2 ER/Outpatient 3□ DOA . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1XX Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed Box 68760. P.0. Records, Division or Vital To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

burial-transit nding physician and ise as the burial-trai atten for u signed by the at d be detached fo cate has been si page 2 should b After the filled in by

show

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined 4 Homicide

29a. Certifier (Check only one)

🔀 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🖆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b.	Signature and	title of certifier	. /
	11	IMIN	ω .
	18	-100	12

18230

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villarreal 31. Date filed (Month, Day, Y 1 4 2007

and manner stated.

Greene Street

State Registrar

Medical

		-	For State Registrar	State of Ma	ryland	-		of Health of Death		lental Hygi	iene .g. No. 2 (007	31	285	
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.and.	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. la	st birthday)	If Under 1 Y		r 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)		lace (State o	or Foreign	
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Maryland 21215-0036	12 sho h and 7 is m traum	1 3	19a. Informant's Name/Relationship (Ty	pe. Print)			•			al Route Number MD 20678	umber, City or Town, State, Zip Code)				
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alti	permit. Pag Department Important: I any Injury o	- 0	21. Signature of Funeral Service Licens	9 12			2. Name and A	Address of Fac							
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sior	endin sath. or: Afi he fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation				M	1 ☐ Yes 2[□No						
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			sician: To the best											
	he Ho n 24 h he Fui pletely	Medical	(Check only 2 Medical Exam one)	iner: On the basis o and manner sta		ion and/or in	vestigation, ir	n my opinion, d	leath occur	rred at the time, o	date and plac	e, and due	to the cause	(s)	
	Vithi To t	Σ	29b. Signature and title of certifier					icense numbe			29d. Date sig	ned (Month	, Day, Year)		
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	Regist	rar	DEP I	(Thou	E STANK	J.J.	6084								

		•	For State Registrar	State of	f Marylan		artment r <i>tificate</i>			and M	lental Hyg R	iene _{eg. No.} 2	007	313	286
£	Physici /Medic		1. Decedent's Name (First, Midd Kenneth P. Kra								2. Date of Dear Month 9/8	/2007	Year	3. Time of	Death 45am
No.	Examir		4a. Facility Name (If not institution 325 Creswell F	_	nber)		4b. City, To		Location o			4c. Cc	ounty of Death nne Arui	nde1	
	Funeral Director		5. Social Security Number 214-18-5584	6. Sex X XM 2□ F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) 3/19/19	Year)	9. Birthp Court Man	lace (State of try) cyland	or Foreign
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. Count MD Anne	Arundel	10c. Cit	y, Town or Lo	cation na Par	k					1	0d. Inside C	ity Limits
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 325 Creswell F	ED.										of What Country?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	mied Armed For	1x√5x(Yes 2 □ No WWTT			Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, €					s or No- s or No- latc.) 14. Race - American Indian Black, White, etc. Specify: White		
	within 72 ho iene, than "natul the Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1	-4or 5+)	(Give	dent's Usual kind of work OO NOT use Drive	done d retired,	lurina mos	t of worki	ing	16b. Kind of Business/Industry Teamsters Union			
Maryland 2	uld be filed Mental Hyg arked other	To Be C	Lewis Kralick Emma Sch							(First, Middle, Maiden Surname) hmidt					
Baltimore, Mary	l and 2 sho lealth and l m 27 Is me her traums		19a. Informant's Name/Relationship (Type. Print) Edith M. Kralick 20a. Method of Disposition 19b. Mailing A 325 Cr				ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Creswell Rd. Severna Park, MD 21146 osition (Name of Date 20c. Location - City or Town, State								
	nit. Pages artment of hortant: If ite ortant: If ite Injury or of E.		★ Burial 2 Cremation 4 Donation 5 Other (Specify)	State C	veter, crei Veter	natory or oth ans Ce	eme t	ery 9	/11/		rowns	sville,	MD	
Ba	permi Depa Impor any fr		19gr J. Cf	/	aused the deat	1.	2 Ridg	gely	Ave.	Ar	napolis	, MD			te
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_a. Me	ach line. TUS or as a conseq	atic			Ca				9.	Approximat Interval Bet Onset and	ween Death YnS
58760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequ										
P.O. Box 68		Physician/Medi						gnancy cify)				230	23d. Date of delivery Month Day Year		Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cau	use give	en in Part I.		V	oacco use	contribute to the	ne cause of d	
Vital Records,	lan: The law re rtificate has be tor, page 2 sho	Be Completed	25. Was case referred to medical	al					26. Place	of Death	24a. Was a autops perform	y	24b. Were auto prior to cor death? 1 □ Yes	psy findings npletion of c	available ause of
Division or V	or Attending Physician: The law requires that the death certifulater death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Certification: To B	3 Suicide 6 Could	ng (Mont igation not be printed 28e. Place	npatient 2 of Injury h, Day Year) of injury - At hong, etc. (Specif	28b. Time of Injury	M 28	lc. Injury Work	4 ∐ Nu	No	me 5 Reside 28d. Describe ho 28f. Location (St City or Town	ow injury o			nber,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifyi	ing Physician: To the I Examiner: On the ba	best of my kno asis of examina ner stated.	wledge, death	n occurred at vestigation, i	t the tim	ne, date an pinion, dea	id place, ith occur	and due to the c	ause(s) ar late and pl	nd manner as s lace, and due to	tated. the cause(s	s)
)	To the Total within Complete C	Me	29b. Signature and little of certific	10	c (M	0	890	License	pumber	4	2	9d. Date s	signed (Month,	Day, Year)	
	Q'E		30. Name and address of person Peter Graze		e of death (Item			λ	mana	. 1 :		2140	1		

10/2

31. Date filed (Month, Day, Year)
SEP 1 3 2007 State Registrar

900 Bestgate Road, Annapolis, MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sinchul Kang September 12 2007 5:03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 24 Capricorn Court Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ₹M 2 □ F Months 217-96-5626 79 Director July 18,1928 Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Capricorn Court 20855 Funeral Korea 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturer 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hangap Kang Aegi Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Midaeji Kang/ Wife 24 Capricorn Court, Gaithersburg, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State September 4 ☐ Donation 5 ☐ Other (Specify) 15, 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not, nter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Aspl Immediate Cause (Final Physician /Medical resulting in death) Due to for as a consequence of) **Examiner** tanpin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy ρ Day 4⊡Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation Sep 12, 2007 1 Yes 2 Accident

Division or Vital Records, P.O. Box 68760, Hospital or Attending n 24 hours after death.

le Funeral Director: A

Certification: To 3 Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

Giograture and title of certifie

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Nome

Dricory

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DO0428 mo oma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 md; cal

ver apring

29c. License number

BKECHER MODME 31. Date filed (Month, Day, Year) Year)

State Registrar

Medical

To the within 2

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			1 - For State Registrar	State of M	laryland / D	epartmen Certificat			nd Men		2 0	07	31288	
	Physici	an	Decedent's Name (First, Middle, Last	•						Date of Death Month 09	Day 18	2007	3. Time of Death	
	/Media	al	Judy Christ 4a. Facility Name (If not institution, give	ine Kotor		4h City	Town or	Location of		09	18 2007 9:00 I			
	Examir	er	607 North Str		,		kland		Codin		Garr			
	Funeral Director		5. Social Security Number 218-64-9008 1	x 7. A	ge (In yrs. last birth	Months		If Under 24 Hours	Min. (Date of Birth Month, Day, Y	9. Birthplace (Sta Country) 54 WV		lace (State or Foreign try)	
	pu .		Usual Residence of Decedent 10a, State 10b, County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town	art casting				., ., , .,				
	fanyla hov	ក											0d. Inside City Limits 1 Yes 2 No	
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	3a or	Ö	607 N.Street				550				U.S.A.		,.	
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Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28e-f ehow other traumatic event, its Medical Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 [X]Divorced	1 Yes 2 If If Yes, Give Year or Dates:	M∑vo	1 ☐ Yes	37	Specify:	7 40110 1 1104	11, 510.)	Specif			
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	i i	Decedent's Usua Give kind of wo	rk done c	lurina most c	of working	16	b. Kind of B	lusiness/Ind	lustry	
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2	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			Homema	ker	18 Mother's	's Nama <i>(Fir</i>	st, Middle, Ma	Se]			
an	d be ental ked o	To Be	Charles Russell N	[cRobie					sephin			,,,,,		
ary	shou Ind M		19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing Address	(Street a			and the same of		. State, Zip	Code)	
Σ	alth a		Joanna M. Upole		8	5 Tanne	ry R	d. 0	Daklan	d, Md.	2155	50		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme eny injury or other traumatic event, the Mudical Expanding Internation 2016.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		comoton	Disposition (Nar crematory or o	ne of ther plac	1	Date 9/21/2		c. Location		wn, State	
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	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):								
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	s that ned b	by Pt	Part II. Other significant conditions co	entributing to death	but not resulting in	the underlying c	ause give	n in Part I.		23e. Did tobac	co use con	tribute to th	e cause of death?	
rds	w require been sig should b	ed b								1 🗆 Yes	2 🗆 No	3 Prob	ably 4 Donknown	
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death (Ch	eck only one)				
of	this aldii	7	1 Yes 2 No	Hospital:				4 🗀 14012	ing Home	5 Residend)	
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Divi	rs efter drain Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of it	njury - At home, fari tc. <i>(Specify)</i>	n, street, factory	/, office			Location (Stree City or Town, S		ber or Rura	Route Number,	
	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes iner: On the basis and manner s	of examination and	death occurred or investigation	at the tim	e, date and pinion, death	place, and o	due to the caus t the time, date	se(s) and m and place,	anner as st and due to	ated. the cause(s)	
	Tot Tot	M	29b. Signature and title of certifier Pourt	niole	- De	290	License	number Cold	14	29d	Date signe	d (Month, I	Day, Year)	
		2	30. Name and address of person who o	completed cause of	death (Item 23a) (T	ype, Print)	Aci	rec 1	Nr (Dakla	and	and	21550	
	Sta		31. Date filed (Month, Day, Year)	0.7	rar's Signature	6								
DH	Registr MH 17 Rev 1/2		SEP 2 0 2	2007	me B	A cook	6							

	Physic /Medi Exami	cal
	uneral irector	
r death with the Maryland	ems 23a or 28a-f show er must be notified at	uneral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Registi DHMH 17 Rev 1/2001

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an	Fredrick Thomas Light				Month	9/9/200	7 Year	8:25pm™					
al er	4a. Facility Name (If not institution, give street and number	-)	4b. City, Town, o	r Location of D			County of Death						
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		ige (In yrs. last birthday)	If Under 1 Year	If Under 24				place (State or Foreign					
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	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Lin						
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Ë	10e. Street and Number		10f. Zip Code			10g. Citiz	zen of What Cou	ntry?					
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ner	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes o	r No- 1	14. Race - Americ						
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ted	15. Decedent's Education	nd of Business/In	dustry										
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E	8	Floris	t.										
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	Surname)											
Ö	Vernon Light			Mi-	nni Tyro	۾ د							
ပ္	19a. Informant's Name/Relationship (Type. Print)	40h Mailie	ng Address (Street				. T O	0.11					
		19D. Mailir	ng Address (Street					o Code)					
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	20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ Removal from Stat	20b. Place of Dispo cemetery, crei	nsition (Name of matory or other pla	се)	Date	20c. Loc	cation - City or To	own, State					
	4 ☐ Donation 5 ☐ Other (Specify)	Hillcrest	t Cemeter	y 9	/13/2007	7 Ann	apolis,	MD					
	21. Signature of Funeral Secure Vicensee	22	2. Name and Addre	ess of Facility	Hardesty	Funer	al Home	. P.A.					
	1.0h		2 Ridgely					,					
	23a. Part1. Enter the disease, r complications that caus shock, or heart failure. List only one cause on each							Approximate Interval Between					
	shock, or heart failure. List only one cause on each Immediate Cause (Final				·			Interval Between Onset and Death					
	disease or condition resulting in death)	nonan	1 Car	reg									
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):												
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윤	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlvina cause giv	en in Part I.	23e.	Did tobacco us	se contribute to t	the cause of death?					
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Completed by Physicia]No 3 ☐ Prol	bably 4 Onknown					
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E O					1 ₀ Y	performed?	death? 1 ☐ Yes	2 No					
BeC	25. Was case referred to medical			26. Place of	f Death (Check o		1 100	20110					
To B	examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ☐ ER/Outpatier	nt 3 DOA Oth	nar:	ing Home 5		Other (Speci	(6.1)					
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edi	one) and manner stated.												
Σ	29b. Signature and title of certifier		29c. Licens			29d. Date	e signed (Month,	Day, Year)					
4	(until tare	~ MD	1	533	06	9	111/07						
	30. Name and address of person who completed cause of	death (Item 23a) (Type	Print)			-	3 3						
	Curtis taris, MD 900	2	RA Sto	300 1	Annapol	18 1	$n \cap \gamma /$	411					
**		strar's Signature			and or		11	70					
ite ar		b 1											
-	SEP 1 3 2007	W DO											

4b. City, Town, or Location of Death

Bethesda

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Ben No.

Liashek

1. Decedent's Name (First, Middle, Last)

Suburban Hospital

4a. Facility Name (If not institution, give street and number)

Annette

Reg. No 2007 31 2. Date of Death 3. Time

4c. County of Death

3:13

Montgomery

рМ

Day 2007

12,

Month

Sept.

Physician
/Medical
Examiner
Funeral
Director

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | 8. Date of Birth | (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number Birthplace (State or Foreign Country) Hours Days 1 ☐ M 2 🔀 F 153-16-4404 85 1, 1922 Feb. New Jersey Usual Residence of Decedent 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 □Yes 2√XNo Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 13900 Turkey Foot Road 20878 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. SpecifWhite þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Pharmaceutical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Corsano Carmela Russolillo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter L. Liashek, Jr./Son 13900 Turkey Foot Road, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept^{Date} 14, 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Metropolitan Crematory 2007 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signal re of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction
Due to (or as a consequence of): 1 Hour /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (also do injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached 1 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Ş Q Hypertension, History of Transient Ischemic Attack, 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of Dementia with Psychosis 24a. Was an autopsy performed certificate | death? 1 ☐ Yes 2 No 2€ No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2☐ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 ☐ Pending investigation Injury n 24 hours after death.

The Funeral Director After the function by the function of the functi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ D0061382 ama 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shana Mittal, M.D.

31. Date filed (Month, Day, Year)

32. Restrar's Signature

14816 Physicians Lane, #152, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2007 Sept. **Physician** 12, 4:00p Alan Roger Leininger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16625 S. Westland Drive Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1**X**M 2□F Days 220-90-1003 45 Maryland Dec. 1, 1961 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d, Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 □ No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16625 S. Westland Drive 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 21 No Specify. Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 12 Carpenter Carpentry permit. Pages 1 and 2 should be filed:
Department of Heath and Mental Hygic
Important; If item 27 is marked other:
any injury or other traumatic event, tf 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Leininger Virginia Diffin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa L. Leininger/Wife 16625 S. Westland Drive, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State September 15, 2007 4 Donation 5 Dother (Specify) Alexandria, Virginia 22. Name and Address of Facility
DeVol Funeral Home, 10
Cairhersburg, MD 20877 21. Signature of Funeral Solice Liceasee East Deer Park Drive Approximate Interval Between Onset and Death A Venier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, occording the disease of each line. Immediate Cause (Final disease or condition Xtensive **Physician** Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1∐ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 1 | Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 □ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 4 hours after death. filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Euneral C tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an 20

State Registrar

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Frederick MD 2/701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

		•	1 - State of Marylar		artmen <i>rtificat</i>			ınd M		giene Reg. No.		7	313	292
		*	1. Decedent's Name (First, Middle, Last)						2. Date of Dea			V	3. Time o	f Death
	Physici /Medi	_	RITA	LEMO	OND				09	Day 15		Year 07	0230	М
	Examir	1.	4a. Facility Name (If not institution, give street and number)			Town, or	Location of	f Death		4c.	County	of Death		
	in the second	÷.	WMHS-BRADDOCK CAMPUS			BERLA				AL	LEGA	NY		
86	Funeral Director		5. Social Security Number 212–90–9905 6. Sex 1 □ M 2 🔀 F 45	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	B. dian	8. Date of Birt (Month Day April	h (, <u>Y</u> ea <u>r)</u> [4	962	Coun	ace (State try) Virgi	_
	pu »	1	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty, Town or Lo	noation							14	0d. Inside C	its Limita
	e Maryla ta-f shov tiffed at	ctor		Barton	Cation									2 <mark>k</mark> No
	th with the 23a or 28 ust be no	Funeral Director	17313 Laurel Run Road		10f. Zip 21	Code 521				-		hat Coun State	•	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	<u>&</u>	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	16a Dece	1 ☐ Yes	28∑M No	Specify:		cify Yes or No- Rican, etc.)		Black Specify:	- America , White, o wh	ite	
1215	within 72 iene. than "na he Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of wo DO NOT u laitre		luring most)	of workii	ng 			urant	-	
CA	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, Last) Robert Keith Kelley JR	1				r's Name ther	(First, Middle,		Surname	9)		
Maryland	and 2 shou salth and M n 27 Is mar ler traumat		19a. Informant's Name/Relationship (Type. Print) Roberta Kaye Cook/ sister						Route Number, Rawl					557
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once.			Place of Dispo cemetery, cre- nberlan	matory or c	ther place	ry	09/1 2007	7/				_{wn, State} ⁄aryla	ınd
Balti	permit. Pages: Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service Licensee J. Wayle Bak	/	2. Name ar 11 C h				al Fund ternpoi			_	2156	52
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						r respiratory ar 1e wit Fem		xten	sion.	Approxima Interval Be Onset and	Death
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P.O. Box 6	ath certific ftending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregrant 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[⊒Ectopic pr ⊒ Other (sp			-			23d. Date Mon	of delive	-	Year
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or Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No Hospital: 1 Inpatient 2 F	3.5D/Q:		Othe	ar.		(Check only o					
n or		on: To	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time o Injury	of 2	28c. Injury Work	at	2	ne 5 ☐ Resid 28d. Describe h				<i>(</i>)	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At homicide building, etc. (Spec	ome, farm, sti fy)	M reet, factor		/es 2□N		28f. Location (S City or Tov	Street an vn, State	d Numbe	r or Rura	l Route Nur	mber,
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			30. Name and address of person who completed cause of death (Ite	m 23a) (Type.	Print)	VIC	TOR	CR	ENTS	3/4	MA		- /	
		6		MBER		VD,	MA	RY	LAND	21	50	2		
7	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign		0									····
	Regist	rar	SEP 1 7 2007	Ally A	Son S	D								

			1 - For State of M Registrar	aryland / Depa <i>Cer</i>	artment of H tificate of L	ealth and N Death	Aental Hygie	ene 2007	31293
	Physici /Medic		1. Decedent's Name (First, Middle, Last) LARRY SEAN MENCH				2. Date of Death Month SEPTEMB		3. Time of Death 0 7 4:17am
•	Examin		4a. Facility Name (If not institution, give street and number) Chester River Hospita		4b. City, Town, or Cheste			4c. County of Dear	th
	Funeral Director		5. Social Security Number 6. Sex 1⊠M 2□ F 7. As	e (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bird (%) 9. Bird (%) 9. 9 (thplace (State or Foreign cuntry) aryland
	Maryland I-f ehow	tor	Usual Residence of Decedent	10c. City, Town or Low Rock Hal					10d. Inside City Limits 1 Yes 2 □ No
	with the	Direc	10e. Street and Number 6030 North Main St.	1.001.1101	10f. Zip Code	1		J. Citizen of What Co	ountry?
036	be filed within 72 hours after deeth with the Maryland lal Hygiene. Id other then "naturel", or lieme 23a or 28a-f ehow event, the Medical Examiner must be maillied at	by Funeral Director	11. Marital Status 11. Marital Status 12. Was Decedent Armed Forces: 1	No If	2166 Was Decedent of Hi f Yes, specify Cuba I□Yes 2∰No	spanic Origin? (Sp	pecify Yes or No-	U.S.A. 14. Race - Ame Black, Whit	
21215-0036	⊆ 2	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or	(Give	dent's Usual Occupa kind of work done on OO NOT use retired	ation during most of won)	king	Marina	/Industry
Maryiand 2	should be filed with nd Mental Hygiene marked other the imatic event, the	To Be C	17. Father's Name (First, Middle, Last) William Ben Mench	1			ne (First, Middle, Ma nce Doro	_{iden Sumame)} thy Urie	2
	nd 2 : lith ar 27 io r trau		19a. Informant's Name/Relationship (Type, Print) Stephanie Balderrama (Zip Code) 20152 ding VA
altimore,	Peges 1 annent of Healint: If item 2		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposer cometery, crem	natory or other plac			c. Location - City or Rock Hal	
Balti	permit. Peges Depertment of important: If it eny injury or once.		21. Sometime Fundal Service To a see	Ga Ga	Name and Address I Lena Fu 8 West	1 P . 114	ome of to Gale	Stephen na, MD.	L Schaech 21635
	Physician		23a Parti. Enter the disease, or complications that cause shock, or head failure. List only one cause on each I Immediate Cause Final disease or condition	ine.				t,	Approximate Interval Between Onset and Death
8760,0	Medical Examiner I bhysicien and streep burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disesse or injury that initiated events c.	a consequence of): L. Myoca a consequence of): Aufluses a consequence of):	endial.	Tufaro	tim		
O. Box 6	death certi e ettending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	tuires that the dein signed by the e	ē	Part II. Other significant conditions contributing to death to the House House Multi-			en in Part I.			o the cause of death?
Division of Vital Records,	sician: The law requires thet the certificete hes been signed by thirector, page 2 should be detache	Completed	End Stage RENAL	litus Sessesse			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
	ysiciar is certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	it 3□ DOA Othe	00	th <i>(Check only one)</i> ome 5 ☐ Residen	ce 6 □Other (Spe	ocify)
o uo	nding Phy ath. r: After thi e funeral	ation; 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ary 28b. Time of Injury	Worl	/at <br Yes 2 □No	28d. Describe how	injury occurred	
Divis	e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifical etely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, stre tc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	24. Cartifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or inv	occurred at the tin vestigation, in my of	ne. Tate and place pinion, death occu	and dua to the cau	e and place, and du	e to the cause(s)
)	To the l within 2 To the I	Σ	29b. Signature and title of certifier	MA	29c. License	2388		1. Date signed (Mon	
	*		30. Name and ddress of person where eled cause of John C. Arrabal, M.D.	death (Item 23a) (Type, 223 High	Print)				
	Sta Registr			rar's Signature	lis CII	.cacertc	WII, MD.	21020	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23 Harold Edward Mullhausen, Sr. September 2007 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2925 Old Taneytown Road Westminster Carroll If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1[XM 2□ F 218-40-2257 Yrs. Director Mar. 12, 1935 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2X ☐ No Directo Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menhal Hyglene. Important: If Item 27 is marked other than "naturar", or items 23a or. many Injury or other traumatic event, the Medical Examiner must be nonce. 2925 Old Taneytown Rd. 21158 Funeral U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) fertillizer Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver/ applicator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be rene Raab Joseph Mullhausen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Mullhausen/wife Westminster, MD 21158 2925 Old Taneytown Rd. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baust Cemetery 9/26/2007 nr. Tyrone. MD 21. Signoure of Funeral Service 22. Name and Address of Facility Hartzler Funeral Home athacere (Har Den 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eleveras **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) P.0. certificate has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 12 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 1 ☐ Yes _ 2 ☐ No 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D To the Hospital 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one.

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

28

2007

and address of person who completed cause of death (Item 23a) (Type, Print) nelletin mD

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Pay, Year)

Physician

/Medical

10a. State

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death nelof 2 1. Decedent's Name (First, Middle, Last) Month mills <ev amont 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manyland Medical Center Baltimore ct If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F 216-75-5023 Usual Residence of Decedent April 29, 2006 Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland | Wicomico Salisbury 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number USA 815 East Church Street 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐ Yes 2 X No Yes, Give 'ear or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 🗷 No Specify Specify: 3 Widowed 4 Divorced Black 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donta Mills Tia Rainer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 815 East Church Street - Salisbury, Maryland Tia Rainer/mother 21804 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Springhill Memory Gdn 09/17/2007 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalule of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 Jollev Memorial Chapel. P. A. 23a. Part1. Enter the disease, or complications that Aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or jach line. Immediate Cause (Final disease or condition resulting in death) Respirator Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiseas of July) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Dertension 1 Yes Kroncho 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner Physician/Medical

Be Completed by Certification: To

burial-tran the attending pl for use as t signed by the a certificate has been si rector, page 2 should director,

the Hospital or Attending Physician; The law requires that the death certificate be executed after death.

Director: / n 24 hours aft le Funerai Di letely filled ir

Medical completely To the within 2 State

Registrar

4 ☐ Homicide 29a. Certifier (Check only one)

29b. Signature and tithe of certifier

27. Manner of Death

2 Accident

3 Suicide

1 Natural

6 ☐ Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

St, Baltimare MD

28d. Describe how injury occurred

D0050845

29c. License number

29d. Date signed (Month, Day, Year) 2007

address of person who completed cause of death (Item 23a) (Type, Print) Name ar

31. Date filed (Month, Day, Year) SEP 12 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 17 31296 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician September 17 2007 11:34 PM Lyda Mae Moore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F July 22, 1923 Director West Virginia 233-34-5428 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny follury or other treumatic event, the Medical Examinar must be received. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Garrett Kitzmiller 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 204 Carl Harvey Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Beulah Snell ပ Lawrence Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deloris Harvey, Daughter 204 Carl Harvey Rd., Kitzmiller, MD 21538 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) I.O.O.F. Cemetery 9/21/07 Elk Garden, WV 21. Signature of Funeral Service License 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A Durdo 710 Church Street, Kitzmiller, MD 21538 Approximate Interval Between Onset and Death 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Emply soma **Physician** 4 ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ souse 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes l lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hapatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA inis Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a Certifier (Check only one)

31. Date liled (Month, Day, Year) 2007

Robert A.

29b. Signature and title of certifier

32. Registrar's Signature

Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goralski,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D23979

311 N. Fourth Street, Oakland, MD 21550

29d, Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 31297 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) o 7 Month **Physician** 5:58 P.M Moore Mary Α. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (ff not institution, give street and number) **Examiner** Alleq. Westernport Moran Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-10-1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2□ F Yrs. 215-10-3529 92 Director MD Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Westernport MD Alleg. Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21562 22601 New Shawnee Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 0 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leradell Lillycrop 2 Walter L Flautt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24609 Pocomoke St Westernport, MD 21562 Mary J. Gulck Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Crematory 9-17-07 Cresaptown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fredlock Funeral Home Piedmont, WV 26750 Jones St. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as/e consequence of) Examiner eral Director: After this certificate has been signed by the attending physician end filled in by the funeral director, page 2 should be detached for use es the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 Tes 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 3□ DOA 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of TONatural 1 ☐ Yes 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: A completaly filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manual as seaso.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 721244 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) frostburg 4 Broad wa resus H Tan Mo mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/1, perPHYS. G872 10/1/07 WS
State of Maryland Department of Health and Mental Hygiene 2007 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

Denise 2. Date of Death 3. Time of Death Ann Nelson Day **Physician** Month Year Melso. 18:41AM 31 ausust 2007 /Medical Facility Name (If not institution, give street and number) 4b. Sity, Town, or Location of Death 4c. County of Death Examiner Sohnes 20 topicins IMORE 8. Date of Birth (Month, Day, Year)
SEPT. 26, 1950 If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | Social Security Number Age (Ipyrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X** F 103-38-0736 Yrs. 56 **NEW YORK** Director Usual Residence of Decedent 10c. City, Town or Location works) 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifiled at 1 ☐ Yes 2X No Director VIRGINIA PRINCE WILLIAM DALE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15005 CLOVERDALE ROAD 22193 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: BLACK Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT VETERANS AFFAIRS 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES C. HENRY ALETHA BOONE ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WINTWORTH NELSON (HUSBAND) 15005 CLOVERDALE ROAD, DALE CITY, VIRGINIA 22193 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FISHKILL CEMETERY SEPT. 8,2007 FISHKILL, NEW YORK 4 Donation 5 Dother (Specify) 22. Name and Address of Facility MOUNTCASTLE FUNERAL HOME 4143 DALE BLVD.
DALE CITY, VIRGINIA 2219 21. Signature of Funeral Service 0502 880045 22193 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 Jays Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal fillure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the ar 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? orthot-pic heart transplant 2 No 3 ☐ Probably 4 ☐ Unknown embolism 1 ☐ Yes been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient ို 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD S Hagin 8/31/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Hagan Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

Registrar

State

Johns Hopkins

3 Registrar's Signature

31. Date filed (Month, Day, Year) SEP 2 8 2007

			For State Of State Registrar	Maryland		artment of H <i>rtificate of L</i>		ientai Hygie Reg	. No 2007	31299
	DI -1-1		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic	_	Margaret Terese Quinn					September	9, 2007	3:28 AM
	Examin	er	4a. Facility Name (If not institution, give street and number	per)		4b. City, Town, or Grasonvi			4c. County of Dea Queen Ann	
-	Funeral		5 Fairway Island 5 Social Security Number 6 Sex 7	. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	•	thplace (State or Foreign
	Director		117-09-6790 1□M 2 □F	91	Yrs.	Months Days	Hours Min.	(Month, Day, Y April 13	1916 N	ew York
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
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_	ter de items iner m	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	ee?		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Whi	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Weight Married 2 ☐ Married If Yes, Give Year or Date	es:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
5	72 hc "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work	ing 16	6b. Kind of Business	/Industry
7	within iene. than the Me	duc	Elementary/Secondary (0-12) College (1-		Home I		,		Own Home	
2	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	uiden Surname)	
<u>8</u>	Ments Ments arked aric ev	To E	James A. Kenny				Anna Min			
<u>a</u>	12 sho n and rism raum		19a. Informant's Name/Relationship (Type. Print)		1	ng Address <i>(Street a</i> irway Isl			Oity or Town, State,	Zip Code)
ָ ע	Healt Healt tem 2		Maureen Quinn/ Daughter 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	- 1		C. Location - City or	r Town, State
Dallillo	Pages ent of nt: If It		1 🖾 Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	tate F	lesurr Ceme	matory or other place ection	9/12/	′2007 C	linton, M	D
2	rmit. spartm portal y Inju		21. Signature of Funeral Service Licensee		2:	2. Name and Addres	ss of Facility Rob	ert E. E	vans Fune	
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	Physician / /Medical		disease or condition a.	or as a consequ	ence of):	19				- Tyear
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	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury	or as a consequ	ience of):					
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S O	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ome pf pregna rth 2 ☐ Feta ant at time of d	Ideath 3	□Ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
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7	s that ned by	by Ph	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
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Š	law r las be	Completed						24a, Was an autopsy perform	prior to	autopsy findings available completion of cause of
<u></u>	n: The licate har, page		DE W				00 8	1 Yes 2,	XNo 1 ☐ Ye	s 2 No
VITAI	Physiclan: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 li	npatient 2 🗆	ER/Outpatie	nt 3 DOA Oth	or:	th <i>Check onlone</i> ome 5 🔀 Resider	nce 6 □Other (Sp	ecify)
פר	ng Phy ter this neral o		27. Manper of Death 28a. Date of	·	28b. Time of Injury	of 28c. Injur		28d. Describe hov		
S S	Attending r death. ector: After by the fune	catic	2 Accident Investigation	Cial a Alba			Yes 2 □ No	Opt Location (Ctr	and Alumbar or I	Dural Pauta Number
DIVISION	al or Attendii after death. I Director: A d in by the fu	Certification:	determined 200. Flace	of injury - At no ig, etc. (Specif		reet, factory, office		City or Town,		Rural Route Number,
	To the Hospital or Attending Physiclan: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) 29a. Certifying Physician: To the 2 Medical Examiner: On the ba	best of my kno	wledge, dea	th occurred at the ti	me, date and place	, and due to the ca	use(s) and manner a	as stated.
	the H hin 24 the F mplete	Medical								
	P. ₹ P. OV	-	230. Signature and mile of certified			D	32353		September	11, 2007
'	100		30. Name and address of person who completed caus 31. Date filed (Month, Day, Year) SEP 1 3 2007	e of death (Item	n 23a) (Type	, Print)	5 6	1 ~ /	h = :://-	MD 21///
	1-		Daniel J. Kunick	m.)	0. 1.	15 Sallit	Vrive, Jui	te E	RVENS VITTE	11/2/666
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3 2007	egistrar's Signa	iture	-				
	n egiot									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 7 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month. 50 M 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Qounty of Death Examiner nun 5. Social Security Number Age (In yrs. last birthdav 8. Date of Birth (Month, Day, Mar 7 Birthplace (State or Foreign
 Country) **Funeral** Months Days Hours 1 M 2 ☐ F 1947 216-44-8538 60 Director Maryland Mar Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Kent Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33069 Walnut Tree Rd. 21651 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1⊠Yes 2□No 1966 If Yes, Give Year or Dates: -1968 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo <u>^</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Chemical Elementary/Secondary (0-12) College (1-4or 5+) Chemical Operator Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Layton Russum Lillian Louise Cornell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys M. Russum (wife) 33069 Walnut Tree Rd. Millington, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Kent Cremation 9/28/07 Smyrna, DE. 4 Dopation 5 ☐ Other (Specify) Fineral Servi 21. Sign atu Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** Achte D Chris /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💯 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 21 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA this 27. Manner of Death 28a Date of Injury 28h Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year 1 Natural 2 Accident 1 Tyes 2 □ No Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51735 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10.41

State

Frederick Delboy,

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 6602 Church Hill Rd. Chestertown, MD.

M.D.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 9:45 PM **Physician** Robertson september 22, 2007 Viola ₋aVerne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lions Center for Rehab & Ext. Care Cumberland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 ☐ M 2 🙀 F MD Mar 17, 88 Director 217-10-1711 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State iten 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√Yes 2□No Cumberland MD Allegany **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 1821 Frederick Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Specify Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Alth and Mental Hyur Is mark 17. Father's Name (First, Middle, Last) land Estella Mary (Sweitzer) Fletterman Karl Erhardt Fletterman ၉ Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 1821 Frederick Street Cumberland Kenneth Robertson husband Department of Health a Important: If item 27 Is any Injury or other training once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 9/24/2007 MD Cumberland 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee Tan . Inter the disease, or convictations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End stage Dementra months Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) P.0. 9∏Unknown 9 Unknown signed by 1 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy 2**X** No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

avern

Walsh

Rd. Cumberland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Morith, Day, Year) SEP 2 8 2007 125 BIShop Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 14,2007 **Physician** ROBERT LUTHER REED JR 12:50 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick
Finder 1 Year | If Under 24 Hrs. Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2∏F Yrs 73 July 17, 1934 Director 216-30-3585 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 No Funeral Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1503 W. Seventh Street 21702 United States 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the M 12 Product Development Leather Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Mae Summers Robert Luther Reed ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1503 W. Seventh Street Frederick, Maryland 21702 Frances C. Reed / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or September 17, 2007 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery Thurmont, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of June 1 Service Licensee 70 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCERONCVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed Ha 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy After this certificate funeral director, pag 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☑No ٩ 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director

completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MILLE 30. Name and ad yess of person who completed cause of Jeath (Item 23a) (Type, Print) 31. Date filed (Monts Par Year) 7 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple 7 Amend #10a-c Per Inf 0872 10/04 after of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 10, CHARLES F. ROSS 2007 10:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 579-76-3121 Yrs. Director 51 JULY 24, 1956 **GEORGIA** Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Prince Georges 1**X** Yes 2 □ No Director NONE D.C. WASHINGTON 10e. Street and Number 8600 Mike Shapiro Dr. apt 801 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 58th ST. N.E. 20019 20735 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ▼ Divorced BLACK Completed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Ith and Mental F 27 Is marked of traumatic ever ARTHUR ဥ **JAMES** ROSS SR. **ESTELL** WILCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau ESTELL ROSS/MOTHER 8600 MIKE SHAPIRO DR. #801, CLINTON, MD. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **GLENWOOD CEMETERY** 9-15-2007 WASHINGTON, D.C. 21. Signature of Funeral Service License 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MMUNO **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last and physician a s the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical as attending properties for use as IF FEMALE: fyes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 2 □ No has been sign 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of certificate ha perform death? 2 No 2 No Be ျှ

or Attending Physician: The law requires that the death certificate be executed this within 24 hours after death To the Funeral Director: completely filled in by the To the Hospital

25. Was case referred to edical examiner?	Hospital: 1 Impatient 2 ER/Outpatient 3 DC	26. Place of Death (Check only one) OA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
27. Mann f Death 1 Latural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	28c. Injury at Work? 28d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory building, etc. (Specify)	y, office 28f. Location (Street and Number or Rural Route N City or Town, State)	umber,

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Pay, Year) 29b. Signatur 29c. License number

who completed cause of death (Item 23a) (T DR. ANTHONY THOMAS, M.D ve

V

State Registrar

Medical Certification:

31. Date filed (Month, SEP 1 1 4 2007

		Please Type or Print in Black Indeling State of Maryland / Departm	ble Ink. Ensure	All Copies A Mental Hydia	en 2 0 0 7	31304
	•	, roi	cate of Death		3. No.	
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death 3:35 A M
/Medi Exami	cal	Jack Symonds 4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Dea		15 200 7 4c. County of Death	3.27 77 "
LXaiiii	ici		red. MD-		Frederic	
Funeral Director			Inder 1 Year ff Under 24 Hr hths Days Hours Mir		(9. Birthp (2. 1927 Vi	lace (State or Foreign htry) rginia
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1		1	0d. Inside City Limits
e Mary Se-f sh	ctor	Virginia Fairfax Fairfax				1√2 Yes 2 No
with th	i Directo		of. Zip Code	10	g. Citizen of What Cour	ntry?
death	Funeral		22031 Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue	(Specify Yes or No-	USA 14. Race - Americ Black, White,	
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28s-f show than "natural Examiner must be notified at	by	1 Never Married 2 Narried 1 No 2 No	es Ž∏ No Specify:	onto ricali, etc.)	Specify: Whi	
72 ho	eted	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of w OT use retired)	vorking	6b. Kind of Business/In	
21215-0036 solvithin 72 hours aff giene. or than "natural", or the Medical Examp	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5 Painte			Self-Emp	loyed
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be itled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural, or items 23a or 28e-f show sny injury or other traumatic event, the Medical Examinative Inditied at once.	To Be C	17. Father's Name (First, Middle, Last) ÜNKNOWN	18. Mother's Na Unkno	ame <i>(First, Middl</i> e, M ΟWΩ	aiden Sumame)	
C should and Mis mer			dress (Street and Number or F			
e, R	1 5	Reggie Symonds – Son 3937 P: 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory	rovidence Pl		CIAX, Va. Z Oc. Location - City or To	
Pages nent of I		1 Surial 2 Cremation 3 Removal from State Cedarwood	,	19/07 E	Edinburg,	Va.
Baltimore, permit. Pages 1 a Department of Hez Important: if item eny injury or othe once.		21. Signature of Funeral Service Licensee 22. Nan	ne and Address of Facility	SOUTH OF THE PARTY	77.7	
4 403 4 4		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	linger Funer oodstock, Va mode of dying, such as cardi	. 22664 iac or respiratory arres	st,	Approximate Interval Between
Physician /Medical Examiner	0 1	shock, or heart failure. List only one cause on each line. fmmediate Cause (Finat disease or condition resulting in death) a	y			Onset and Death
60, %	Examiner	Sequentially list conditions, It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
3760, ate be exc hysician a	70	Due to (or as a consequence of):				
.O. Box 687 the death certificate by the attending phys ached for use as the	by Physician/Medic		ppic pregnancy er (specify)	\	23d. Date of delive	ery Day Year
S, P		Part If. Dther significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
Vital Record sician: The law requir certificate has been si rector, page 2 should	Completed			24a. Was an	prior to co	opsy findings available ompletion of cause of
				perform	ed? death?	2 □ No
of Vita Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3	Othor	Death (Check only one Thome 5 Resider	nce 6 Other (Speci	(v)
O E = E	ion: T	27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		
Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)		28f. Location (Str City or Town,	eet and Number or Rur , State)	al Route Number,
Divisi To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occ (Check only one)	urred at the time, date and pla gation, in my opinion, death oc	ace, and due to the ca courred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 Fo the comple	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month)	Day, Year)
. 770		blug MD	D0060417		9.16.0	7
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Hemen Shah GSC: Thomas 700	linsen sv.	TWADO.	TUC HI	5 2.17/13
and the second second	tate	31. Date filed (Month, Day, Year) 2. Registrar's Signature)	P V CD CV		3 - 110
Regis	trar	SEP 2 8 2007 Januar J. Species				

Director

Be Completed by Funeral

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Certification: To Be Completed by Physician/Medical Examiner

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Physician /Medical

Examiner

Funeral

Director

Department of Heath and Mental Hygiene. Important: or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

	Please T					nk. Ensure Al			Legible.	
For State Registrar		State of IVI	aryiand / I			f Health and M of Death	-	giene Reg. No.	2007	31305
	(First, Middle, Last)						2. Date of De		Year	3. Time of Death
MARGA	RET Mac	EWAN SCA	AIFE				Sept	. 2 ^a 2	2007	3:21P M
	not institution, give s			4		n, or Location of Death		4c.	County of Deat	
	ista Med				Lap	lata ear If Under 24 Hrs.	0 Date of Bir	46	Charle	
Social Security Nu 566–48–	·4110	M 2 F	ge (In yrs. last bi			ays Hours Min.	8. Date of Bir (Month, Da 9 – 22 –	1941	TEN	hplace (State or Foreign untry)
ual Residence of a. State	Decedent 10b. County		10c. City, Tov	vn or Loca	tion					10d. Inside City Limits
MD.	CHARL	ES			WALDO	RF				1 □Yes 2 No
. Street and Nun	nber		1		10f. Zip Co	de	1	10g. Citiz	zen of What Co	l ountry?
	0 SORREL	RIDGE	LANE			20601		U.S.	.A.	
Marital Status		12. Was Decedent	Ever in U.S.	13. Wa	as Decedent	of Hispanic Origin? (Sp	ecify Yes or No)-	14. Race - Ame	
1 □ Never Marri	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No		/es, specify ☑Yes 2[☑	Cuban, Mexican, Puerto No Specify:	rican, etc.)		Black, White Specify: WH	
3 ☐ Widowed	4 ☐ Divorced	Year or Dates:				но ореспу.			Specify: WIT	115
	15. Decedent's Edu ify only highest grad	e completed)		(Give kir	nt's Usual O nd of work d NOT use re	one during most of work	ding	16b. Kii	nd of Business/	Industry
lementary/Seco	ndary (0-12)	College (1-4or	· ·		ı MAN			PET	CO STO	RE
	First, Middle, Last) AN MacEW	/AN				18. Mother's Nam			Surname)	
	me/Relationship (Ty		19	b. Mailing	Address (St	reet and Number or Ru	ral Route Numb	er, City o	r Town, State, 2	Zip Code)
	Y W.SCAI		1			EL RIDGE				
a. Method of Disp	osition		20b. Place	of Disposit	tion (Name o	of	Date	20c. Lo	cation - City or	
1 ☐ Burial 2 [Cremation 3 F	lemoval from State	ETROPO	ery, crema)LITA	atory or othe AN CR	EMATORY 9	-26-07	ALE	X.,VA.	
	5 LI Other (Specify) neral Service Licens			121	Name and A	ddress of Facility				
Mi.	la O	0.10041	-	RA	NOMYP	D FUNERAL TA.MD. 20		ICE,	P.A.	
la. Part1. Enter ti	ne disease, or compl	ications that cause	d the death. Do	not enter	the mode of	f dying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
mediate Cause (Final	ne cause on each ا	ine.		7	Marit Harris				Onset and Death
sease or condition sulting in death)		a. Due to for a	a consequence	-	near	& dise	evil.			
				/-						
equentially list country, leading to im		Due to (or as	s a consequence	e of):						
use (Disease or it initiated events	injury									
sulting in death) l	ast	Due to (or as	s a consequence	e of):						
		d								
								1:		
FEMALE: 3b. Was deceden in the past 12 1 Yes 24 9 Unknown	months?		e pf pregnancy 2 □ Fetal dea at time of death		Ectopic pregr Other (s <i>peci</i>		<u></u>		23d. Date of de Month	elivery Day Year
	icant conditions co	ntributing to death	but not resultina	in the und	lerlying caus	e given in Part I.	23e. Did	tobacco u	use contribute t	o the cause of death?
3111		9					1	Yes 2	□No 3□P	robably 4 Unknown
							04- 111		0.45 14/	utanau findir sa susitat ta
							24a. Was auto peri 1 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of s 2 No
. Was case refer	red to medical					26. Place of Dea			1 1016.	
examiner? 1,	i i	Hospital: 1 ☐ Inpat	ient 2 ☑ ER/C	Outpatient	3□ DOA	Other:			6 ☐Other (Spe	ecify)
. Manner of Deat	h	28a. Date of In	jury 28b	. Time of		Injury at Work?	28d. Describe			
Natural Accident	5 Pending investigation	(Month, D		Injury	М	1 ☐ Yes 2 ☐ No				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of in building, e	njury - At home,	farm, stree	et, factory, o	ffice	28f. Location	(Street ar	nd Number or F	Rural Route Number,

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 % 9

Medical

within 24 hours after death

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 25500 Pt. Registrar's Signature Yahia Tagouri MD Lookout Rd., Leonardtown MD, 20650

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-50883

29d. Date signed (Month, Day, Year)

amen aaco	d line hlth	1 de	pt 9/13/	/ Ple a /07 d.	ase Type or Pi Lw State of I					. Ensure A lealth and N			egible.	
			1 - For State Registrar 1. Decedent's Name	e (First, Midd	#e, Last) Thomas		Ce	ertificat	e of		2. Date of D	Reg. No. 2	001	3 3 6
	Physicia /Medic	al						-		legal	1	mber ^{ay} 8		5:45 A M
	Examin	er	Solomon 1		on, give street and numbers g Center	er)			omor	or Location of Death	1		ounty of Deat lvert	.in
	Funeral Director		5. Social Security N 215-32-49	925	6. Sex 1 M M 2 □ F	Age (In yrs.		/) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 5/2/19	irth Day, Year) 934	Co	thplace (State or Foreign buntry) Limore,MD
	yland Iow		Usual Residence of 10a. State	10b. Count	•	10c. Cit	ty, Town or I	_ocation						10d. Inside City Limits
	ne Mar 8a-f sh ptiffied	ector	MD		lvert		Lus							1 ∐Yes 21XINo
	a or 2	E Dir	10e. Street and Nur 11448 Ho	mber orsesh	oe Trail			10f. Zip	Code	20657		10g. Citize	n of What Co USA	ountry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed		If Yes, Give	s? ⊒No Kor	.s. 13	B. Was Deced If Yes, spec		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: Wh	e, etc.
5-0	72 hou 'natura dical E	eted	(Spec	15. Decede	nt's Education est grade completed)		16a. Dec	edent's Usua e kind of wo	al Occup rk done	oation during most of wor d)	king	16b. Kind	of Business/	Industry (Industry
121	within iene. than '	Completed	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)	Fore		se retire	d)		Con	struct	ion
nd 2	e filed tal Hyg dother	Be C	17. Father's Name	•						18. Mother's Nam				
r Zla	should be f and Mental I s marked of umatic eve	2	George S				10h Mai	iling Addross	(Stroot	Maomi D		hor City or 1	Town State	Zin Codo)
Ma	s 1 and 2 s of Health an Item 27 Is r other traur		Ruby Sch		Wife					oe Trail				zip Code)
Baltimore, Maryland 21215-0036	Pages 1 ann of He		20a. Method of Disp 1 ☐ Burial 25		3 □Removal from Sta	20b. F	Place of Disponentery, cr	position (Nan ematory or o	ne of ther plac		Date		tion - City or	
Itim	nit. Pa artmen ortant: Injury		4 □ Donation 21. Signature of Fy			Me		remato 22. Name an		9/15 ess of Facility Ha			nore, l	
B	permi Depar Impor any Ir		多). Gr						y Ave. An				
8760,	Physician /Medical Examiner Medical Examiner Final Fi	dical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list contrains, reading to incause. Enter Unde Cause (Disease or that initiated events resulting in death) I	on inditions, innediate erlying injury	b. Due to (or	as a consequence as a c	uence of):	rwi	ith.	meta	stat.	ic D	ોડલક	Onset and Death CL MONHIS
.O. Box 6876	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the bunal-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outco 1	n 2 ☐ Feta t at time of c	al death 3	l⊟Ectopic pr i		у		23	d. Date of del Month	livery Day Year
ds, P	w requires that s been signed b should be deta	by Pi	Part II. Other signif	ficant condit	tions contributing to deat	h but not res	ulting in the	underlying c	ause giv	en in Part I.		l tobacco use	~ /	the cause of death?
ecor	taw requas been 2 shoul	Completed by	COPD								24a. Wa	s an opsy	24b. Were au	utopsy findings available completion of cause of
a B	sician: The law certificate has b irector, page 2 s										per 1□ Yes	formed2	death?	2 □ No
Z,	nysician: iis certific director,	To Be	25. Was case refer examiner?		al Hospital: 1 □ Inp	atient 2	ER/Outpati	ent 3 DO	Oth	26. Place of Dea			Other (Soe	cify)
o u	aling Phys	on:	27. Manner of Deat	5 Pendi	irig	njury Day Year)	28b. Time Injury		8c. Injui Wor	ry at rk?	28d. Describe			,
Division or Vital Records, P.O	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could	minod 200. Place of	injury - At he etc. <i>(Specil</i>	ome, farm, s fy)	M street, factory		Yes 2□No		(Street and own, State)	Number or Ru	ural Route Number,
Ω	Hospital o		29a, Certifier	1 Certify	ing Physician: To the be	est of my kno	owledge, de	ath occurred	at the ti	me, date and place	e, and due to th	e cause(s) a	nd manner as	s stated.
	the Ho hin 24 I the Fu	Medical	(Check only one)		and manner	s of examina stated.	ation and/or				rred at the tim			
	6 in 6 20	-	29b. Signature and	Title of certifi	(290	Licens	se number		· ·	1	th, Day, Year)
	10, De	7	30. Name and addr	ress of person	S. MD n who completed cause of TAU (UI) 110	of death (Iten	n,23a) (Type	1#211	100	ince Fred	louise	iUD	ubër 11 2068	2007
	Sta Registr		31. Date filed (Mon	-	3 2007	istrar's Signa	ature	back	•	1100190	ur Cu	1-01	- WIN)

		Pleas	e Type or Prin						-		•		
		For State	State of Ma	aryland		*			/lental Hy	giene			
		State Registrar 1. Decedent's Name (First, Middle,	(not)			Certificate	Of L)eath	2. Date of De	Reg. No.	2007	3	307
Physicia		CHARLE	,	SMA	LLWC	OD SR			Month	Day	Year L4,2007	5:39	A ^M
/Medic Examin		4a. Facility Name (If not institution,		- Original Control	шичс			Location of Death	pep cem		County of Death		A
Lxuiiiii	٠.	Frederick Memo	rial Hospit	al		Fre	der:	ick		I	k		
Funeral		,	153 M 2□ E	e (In yrs. I		Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	ay, Year)	Cot	place (State or	Foreign
Director		217-10-0672 Usual Residence of Decedent		92	Yr	s.			May 30	, 191	.5 <u>Ma</u>	ryland	
yland now at		10a. State 10b. County		10c. City	, Town c	r Location						10d. Inside Cit	y Limits
e Mar la-f sk tiffed	Director	Maryland Fred	lerick	Knoz	vil	le						1 □Yes	2 X No
or 28	Dire	10e. Street and Number				10f. Zip C	Code			10g. Citi	izen of What Cou	intry?	
eath v is 23a must	eral	4119 2nd Street	12. Was Decedent	Ever in 116		12 Was Dagada		1758	acifu Vac ar N		nited St 14. Race - Amer		
fter de r item iner r	Funeral	11. Marital Status 1 □ Never Married 2 X Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ 1		o.			spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	5-	Black, White		
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	X No	Specify:			Specify: B	lack	
72 hc 'natuı	Completed	15. Decedent's (Specify only highest	s Education grade completed)	I.	(0	ecedent's Usual Give kind of work	done d	luring most of worl	king	16b. Ki	ind of Business/I	ndustry	
within ene. than '	ld m	Elementary/Secondary (0-12)	College (1-4or 5	i+)		fe. DO NOT use		,		n .	0 D-41	1	
filed v Hygie		17. Father's Name (First, Middle, L	ast)	l	KC	undhous	e Ur	18. Mother's Nam	e (First, Middle		0 Rail Surname)	road	
lid be fental rked c	To Be	Marshall C. Sma	11wood					Lily Mae	e Weedo	n.			
shou and M		19a. Informant's Name/Relationshi			19b. N	failing Address (Street a	and Number or Ru			or Town, State, Z	ip Code)	
and 2 ealth m 27 i		Agnes B. Smallw	ood/Wife	1				et, Knoxy					
ges 1 If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		C	emetery,	isposition (Name crematory or oth	ner plac	í i .	Date	20c. Lo	ocation - City or	Fown, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Pages 1 and 2 should be filed within 72 hours after death with the Maral Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		St	. Ma:	ry's Cem					ersville	,Maryla	ind
perm Depa Impo any l		21. Signature of Varietal Service E	Mann	1	/	Stauff	er I	s of Facility Funeral H Sumtown H	lomes P	. A. reder	rick Mar	vland 2	1702
N F 10		23a. P. 11. Enter the disease, or o shock, or heart failure. List of	complications that caused	the death	. Do no						. 1010 1141	Approximate Interval Bety	
Physician		Immediate Cause (Final disease or condition				cardia	1	infarc.	hhn			Onset and D	Death
/Medical		resulting in death)	a. Due to (or as				1	1.1100 01	(Cor)			num	,100,
Examiner	<u>.</u>	Sequerically list conditions,	. Cover	ary	α	rtery	au	sease				years	
ted nsit	Examiner	Sequernially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ierice di)							ι	
executed n and ial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of)	•							
eath certificate be executed attending physician and for use as the burial-transit	_		d										
The law requires that the death certificate tite has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medica	IF FEMALE:											
w requires that the death cer been signed by the attendin should be detached for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death	3 ☐Ectopic pre					23d. Date of deli Month	*	/ear
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	eatn	5 ☐ Other (spe	спу)						
that ned by deta		Part II. Other significant condition	ns contributing to death b	ut not resu	ılting in t	ne underlying cau	use give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of d	eath?
quires	ed by	chronic ok	Structure	pul	mo	rang d	UG P	ase	1	Yes 2	No 3□Pr	obably 4 □U	Jnknown
le law re has bee ge 2 sho	plet	hypertensio	Λ						24a. Wa	s an		topsy findings a	
The ate has page	Completed	(*								iormed? 2 X No	death?	2∏ No	ause or
Iclan: Sertific Sector,	Be	25. Was case referred to medical examiner?	Heavitali				100	26. Place of Dea	th (Check only	one)			
Attending Physician: r death. ector: After this certifice by the funeral director, i	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outp 28b. Tir	atient 3 DOA		4 □ Nursing H	ome 5 ☐ Res 28d. Describe		6 Other (Spec	cify)	
dlng h. After funer	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da		Inji	iry M	ic. Injury Work 1 □ '	yai ⟨? Yes 2∏No	Zou. Describe	riow inju	ry occurred		
Atten r deat ector by the	ifica	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of inj	ury - At ho	me, farm	n, street, factory,	office		28f. Location	(Street ar	nd Number or Ru	ral Route Num	ber,
talor rs afte al Dir	Certification:	4 Littornoide	building, et	c. (Specif)	'/ 				City of To	own, State	<i>₹/</i>		
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medical E	Physician: To the best examiner: On the basis of	f examina									5)
Fo the swithin 2. Fo the somplet	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29c.	License	e number		29d Da	ite signed (Monti	n Day Year)	
F 3 F 8		Valledon	11) Sen U	2			7	2073		6	7/11/20	1, 5ay, 16an,	
Y		30. Name and address of person v	who completed cause of c	leath (Item	23a) (T	/pe, Print)	11	12013			1117/20	07	
		Kathleen W	Stern MO,	61	10	Ninth	av	e number 32073 L, Brw	nowick	1,1	1d, 21	716	
Sta		31. Date filed (Month, Day, Year) SEP 1 7	32. Pegistr	ar's Signa	ture	1		/		,			
Registr	ar	OLF I (LAUI MA	W A	1	CONTRACT.							

			1 - For State Registrar	State of M	larylan	_			lealth a			Reg. No	2 U U	7	3 3	08
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of De Month	Day			3. Time of	
	/Medi	cal	Agatha M. Savage				41 63				Septemb		13, 20 County of E		10:34	P ^M
7	Examir	ner	4a. Facility Name (If not institution, giv						r Location o	of Death						
	Funeral		Northampton Manor 5. Social Security Number 6.5	ax 7 A		last birthday)	If Unde	eric r1Year	If Under		8. Date of Bir (Month, Da	<u>Fr</u> €	ederic 9.	K. Birthpl	ace (State o	r Foreign
	Director		217-48-1497	☐M 2☐¥F	84	Yrs.	Months	Days	Hours	Min.	May 13	$\frac{1}{3}$, $\frac{1}{3}$			ny) inia	
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or Lo	cation								Od. Inside Cit	ty Limits
	anyla hov	ក		-1-											1 🗆 Yes	
	the N	ect	Maryland Frederi	-CK	<u> </u>	rederi		o Code				10a. Cit	izen of Wha	t Coun	iry?	
	Sa or	<u> </u>	10896 Martingale	Court			1000		21701				U.S.A		•	
	72 hours after deeth with the Maryland naturel', or Items 23a or 28a-f ehow dical Examiner must be notilied at	Funeral Director	11. Marital Status		t Ever in U	.S. 13.	Was Dece				cify Yes or No Rican, etc.))-	14. Race - A	America		
9	or Its	F	1 Never Married 2 Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	No				Specify:		nican, etc.)		Black, V Specify:			
215-0036	urel',	d by	3 □ Widowed 4 □ Divorced	Year or Dates	:						1	ic.				
<u>5</u>	nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usu kind of wo DO NOT u	ork done i	durina mos	st of worki	ng	1	ind of Busine			
212	within ene. then	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)		d Se		,			!	olic S		_	
	Hygir other	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
<u>a</u>	fental fental rked c	To B	Charles Rau						Ne.	llie	Smith	L				
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	-	19a. Informant's Name/Relationship (**			•				Route Numb					
	and 2 ealth m 27		Judith D. Owen	s - Daugh							, Fre					21701
Baltimore,	Pages 1 ar nent of Hea int: If Item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from Stat		Place of Dispo cemetery, crei					ate		ocation - City			
ij	tant:		4 □ Donation 5 □ Other (Speci	(y)	Re						9/18/					
Bal	permit. Pages 1 Department of H Important: If Ite any injury or ot ance.		21. Signature of Funeral Service Lice	nsee ////	•	The street of					sworth				neral 20872	Home
			23a. Part1. Enter the disease, or com	plications that cause	ed the deat			1					путап	u T	Approximate Interval Bets	е
	Physician /Medical Examiner	iner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of second	uence of):	ena	e f	si les	u -	u				Onset and I	Death
68760,	taw requires that the death certificate be executed as been signed by the ettending physician and 2 should be detached for use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a conseq	uence of):										
.O. Box	at the death certifica by the ettending ph tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3[⊒Ectopic p ⊒ Other (s						23d. Date of Month			Year
<u>α</u>	quires that the signed by all did be detacted	þ	Part II. Other significant conditions. Hypert cw.	contributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part I	l.		tobacco Yes 2	use contribu	te to th		leath? Jnknown
Records,	The law requir ete has been si page 2 should	Completed	1' Dem	enta							24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior deat	r to cor th?	osy findings npletion of c	available ause of
Vital	ysician: The is certificate his director, page	a l	25. Was case referred to medical		252				26. Place	e of Death	Check only		, , ,	103	20110	
† \	Physician: this certificant	To B	examiner? 1 ☐ Yes 2∑ No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatier	nt 3 D	OA Oth	ier: 4 💢 No	ursing Ho	me 5 Resi	idence	6 Other (Specify)	
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, E	ijury Da <i>y Year)</i>	28b. Time o Injury	ıf	28c. Injur Wor	y at k?		28d. Describe	how inju	iry occurred			
Sio	Attending or death.	catl	2 Accident investigation 3 Suicide 6 Could not to	10			М		Yes 2 🗆			10.				
Division		Certification:	4 Homicide determined	building,	etc. (Specii	(y) 					28f. Location (City or To	wn, Stati	θ)			10er,
	To the Hospital or within 24 hours effet To the Funeral Dir completely filled in	Medical		hysician: To the bes miner: On the basis and manner:	of examina											5)
	To th within To th compl	Me	29b. Signature and title of certifier	Van n	1D.		29	c. Licens	e number			29d. Da	ate signed (A	Aonth,	Day, Year)	
			-	r	-		I	5463	16		5	Sept	ember	14.	2007	
	22		30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type,			-			-				
	7		Syed W. Haque, M	D, 700 Mo	ntcla	ire Av	enue,	Fre	deri	ck, M	larylan	d 2	1701-4	4509)	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32. Rygis	strar's Signa	ature	Cart.	2								

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of F			ene 2007	31309													
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Floyd Randolph Snowden			2. Date of Death Month September	Day 6 2007														
}	Examir		4a. Facility Name (If not institution, give street and number) 410 Granville Cowt 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre	or Location of Death de Grace If Under 24 Hrs.		4c. County of De														
	Funeral Director		219-88-2821 1 ■ M 2 □ F 41 Yrs. Usual Residence of Decedent	Months Days	Hours Min.	8. Date of Birth (Month, Day, 08/21/1	966	D.C.													
	he Marylan Ba-f show	ector		e de Grac	e			10d. Inside City Limits 1 Yes 2 No													
	with th	Dire	10e. Street and Number 410 Granville Court	10f. Zip Code 210	78	10	g. Citizen of What U.S.A	,													
036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be motified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian,													
Baltimore, Maryland 21215-0036	d within 72 ho plene. r than "natur the Medical I	ompieted	Completed	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing 1	6b. Kind of Busines	ss/Industry												
nd	be filectial Hygod of other	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, M	aiden Sumame)														
ıryla	should nd Men marke matic	ဥ	Elliott Floyd Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailli	na Address (Street	Shirley and Number or Run		-	Zin Code)													
, Ma	end 2 salth ar n 27 is er trau		Brandy Lee Snowden (daughter) 12099	94th St	reet. Nor																
Jore	ages 1 nt of He ii if Iten		1 Burial 2 M Cramation 3 D Removal from State Cemetery, crei	matory or otner pia	CO)																
altin	mit. Postmer				Inc 09/1																
ã	Depe impo any ir		I man 1	123 S. Wa.	shington	St. Hev.	no do Gna	ce, ND 21078													
	Physician /Medical Examiner	Completed by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	dicai	dicai	dicai	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List on the end cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	A 1 1	e head		st,	Approximate Interval Between Onset and Death								
8760,	14.							dicai	cai Examiner	cai Examiner	cai Examiner	cai Examiner	ai Examiner	ai Examiner	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Erries underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
.O. Box 68	ne death certifi the attending thed for use as									□Ectopic pregnance □ Other (specify)	у		23d. Date of c	delivery Day Year							
<u>α</u>	w requires that the bound by should be detected by the period by the				Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	1.0	to the cause of death? Probably 4 □Unknown											
al Records,						24a. Was an autopsy perform	prior t														
Vital	rsician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 17 Yes 2 □ No Hospital: 1 □ Inpatient 2 □ EP/Outpatier	nt 3□ DOA Ct	26. Place of Deat	h (Check only one	nce 6 Other (Sp	nagifu)													
n of	ng Phys fter this ineral di		27. Sanner of Death 1 Natural 5 Pending (Month, Day Year) Injury	II 3 DOX	ry at	28d. Describe how		овсту)													
Division of	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 2. Place of Injury - At home, farm, str building, etc. (Specify	AM 10	Yes 2 No	28f. Lo ation (Str. Cit or Town,	eet Ind Number or Stre)	Rural Route Number 1076													
	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deatt and manner stated.	h occurred at the til ivestigation, in my (me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)													
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. Licens			d. Date signed (Mo														
1	3		30. Name and address of person who completed cause of death (Item 23a) (Type,	Deint)	14206	Se	plember	17,2007													
1	J		BERNARD YUKNA, MIDDAE 1614 CH	LYRCHVIL	14206 LE ROAD	BEL AIR	Md 210.	15													
	Sta Registr		31. Date filed (MorSEP Year) 9 2007 32. Ingistrar's Signature	Conto																	

SNOWDEN, FLOYD

State of Maryland / Department of Health and Mental Hygiens 3 | 3 | 0 1 - For State Registrar Reg. No. Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3 Time of Death Month 9 320 Yea **Physician** Vlar 4 M 0 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Garrett Goodwill Mennonite Home Grantsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, 1917 May 3, 1917 5. Social Security Number 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min New York 90 Yrs. Director 107-03-5099 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County or 28e-f ehow treumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No MD Prince Georges Greenbelt 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23e USA 20770 death Funeral 22 Ridge Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiane. Item 27 le marked other than "natural", or Item 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Council of America Elementary/Secondary (0-12) College (1-4or 5+) Distilled Spirits 12 Statistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Burford Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Killdeer Lane, Grantsville, MD Nadia Khattak/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If its eny injury or ot. Pages 1 1 XBurial 2 Cremation 3 Removal from State Grantsville Cemetery Sept. 17, 2007 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furniral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A. A JEN P.O. Box 275, Grantsville, MD 21536 mai 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** pertiensi On 1.15 /Medical Due to as a consequence of): Examiner (and fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed heihen (or as a consequence of) Box 68760 abet Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ poth 1 Yes 2 No 3 Probably 4 Unknown roic Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 \(\int \) No 20 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: ٩ 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Aftar this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural aftar death.
I Director: Aft 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 58655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32 Grantsville ornorate Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEM/7 DerFH G872 10/2/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Month LEONTINE FELICITY TANSILL ,2007 7:30P.M.M SEPT.23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4629 DULEY DRIVE WHITE PLAINS CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 F 94 Director 578-14-7370 FEB.21,1913 WASH.,D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh CHARLES MD. WHITE PLAINS 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o o 4629 DULEY DRIVE ral", or items 23a Examiner must b 20695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ Specify: WHITE 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LIBRARY OF CONGRESS Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. AQUISTIONS ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE WILLIAM GALLAHORN ပ္ LEONTINE BURRUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tra MICHAEL CONNOLLY-SON 4629 DULEY DR. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or ST.JOSEPH'S CEM. POMFRET, MD. 9-27-07 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee MOQ479 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each live. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a con equence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No fter death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Mg

Old

12070

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2007

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

a or 28a-f show be notified at

items 23a ciner must be

ו "natural", or item: ledical Examiner ח

permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural any injury or other traumatic event, the Medical Ex. once.

filed within 72 hours after death with

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

burial-tran attending physician for use as the buria signed by the a d be detached f page 2

certificate

this funeral

After

death.

5

within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu

To the Hospital o within 24 hours aft To the Funeral D

certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Physician:

Examiner Physician/Medical þ Completed 25. Was case referred to medical Be 27. Manner of Death Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter United him Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension

examiner?

1X Natural

2 Accident

(Check only one)

3 ☐ Suicide 4 Homicide

29a. Certifier

1 ☐ Yes 2 No

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 5 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 26. Place of Death (Check only one)

Other: $_{4\square \, \text{Nursing Home}}$ 5 $\square \, \text{Residence}$ 6 $\square \, \text{Other} \, (\textit{Specify}) \, \text{Asst.}$ Lvg.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Iniury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

MID. 30. Name and address of person who conveted cause of death (Item 23a) (Type, Print)

D56531

9/14/2007

8600 Snowden River Pkwy, Ste.301 Columbia, MD Harry Li, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 17 2007

5 Pending investigation

6 ☐ Could not be



Pamela	Sue	Varner	

		1- For State Registrar		Certificate of Death				Reg. No. 2007 3131				
Physicia	in/	Decedent's Name (First, Middle,Last)						2. Date of Death 3. Time of Death Month Day Year 1501 hrs				
ledical Exami	ner		Pamela S	ue V				September	19, 2007		rs	
		 Facility Name (if not institution, give West Lake Bivd. 	street and number)			City, Town, or Prince Fred	Location of Deat	tn	4c. County of D	eatn	ľ	
Franci	-	5. Social Security Number 6. Sex	7 Age (li	n yrs. last b		f Under 1 Yea		rs. 8. Date of Birth	(MM/DD/YYYY) 9	. Birthplace (Stat	e or	
Funeral Director			M 2 XF			Months Day		n.	F	oreign CountryMic		
	-	Usual Residence of Decedent	M Z AF	53	Yrs.			May 17	,1954			
any		10a. State 10b. County	100	c. City, Tov	vn or Location					10d. Inside	City Limits	
nd show	-	Maryland Calve	rt i			Prince	e Frede	erick		1 X Yes	2 No	
daryland 28a-f show any d at once.	Director	10e. Street and Number				Of. Zip Code			g. Citizen of What	Country?		
th the Maryland 23a or 28a-f sho notified at once		105 West Lake	BLVD.			2	0678	τ	J.S.A.			
with ms 23	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.			spanic Origin? (s n, Mexican, Puerl	Specify Yes or No-	14. Race - A White, e	merican Indian, E	3lack,	
death or ite	Ē	1 Never Married 2 Married	1 Yes 2 X	No				to rudan, oto.,		**		
s after	à	3 Widowed 4 X Divorced	or Dates:			s 2XX No	specify:	fwat dana	Specify:Wh			
hour "natu	ompleted	15. Decedent's Education (Specify onl	College (1-4 or 5+)	16			e. DO NOT use re		TOD. KING OF BUSH			
136 hin 73 e than	亂	1.0	Sollogs (1 Tot 5)	A	cting	Di reci	torAudi	t i naDer	ot.U.S.C	Covernm	ent	
5-0036 iled within 7 Hygiene 1 other than the Medica	Son	17. Father's Name (First, Middle, Last)			.ccing	71100		ne (First, Middle, M		70 V CI IIII	CIIC	
21215-0036 Juld oe filed within 72 hours after Mental Hygiene. marked other than "natural", ic event, the Medical Examiner	Be		Virgil Mc	Mann				ra Anr				
b, MD 21215-0036 and 2 should oe filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Ty	' '						ber, City or Town,			
e, MD 2 and 2 shou fealth and N tem 27 is n traumatic		Virgil McMann	rather		2961 2			Date Date	ty, Mich			
nore, ages 1 a nt of He nt: If ite		1 Burial 2 X Cremation 3	Removal from State	cren	natory or other	place)						
Baltimore, permit Pages I an Department of Her Important: If ite		4 Donation 5 Other Specify:		Bayv	iew C				Baltimo			
Baltimore, MD 21215-0036 permit Pages I and 2 should oe filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Funeral Service Licens	nn		22. Nam	e and Addres	S of Facility Ma	arzullo	Funeral	Chape	1, P.A	
Physician	\dashv	23a. Part I. Enter the disease, or coople	ications that caused the	death. Do	not enter the	9 Har mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approxim	ate Interval	
/Medical	ļ	failure. List only one cause on each	^{ch line.} Asphyxia and Blur				7			Between	Onset and eath	
xaminer			Due to (or as a consequ		injunes							
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	j.	cause. Enter Underlying Cause	Due to (or as a consequ	ence of):			-1					
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760, cate be execute physician and he burial - tran	/Medical	UNPENDED	PMENDED									
3760, ificate be ig physici s the buri	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnan	cy Fetal	death 3	Ectopic preg	nancv	23d. Date of de Month	Day	Year	
Box 68's e death certifithe attending ed for use as the strending ed for use ed	sician	past 12 months?	4 Pregnant at tim	e of death		(Specify)		,		ŕ		
Bo le deat the at	Phys	1 Yes 2 No 9 V Unknown	g Unknown			_		Too Did.			5 do - 40 O	
ires that the disagned by the	by P	Part II. Other significant conditions	contributing to death bu	ut not resul	lting in the und	erlying cause	given in Part I.		bacco use contribu			
S, F quires en sign						<u> </u>		24a. Was		re autopsy finding		
aw rea	Completed							autop	sy prio	or to completion o		
tal Rec sian: The certificate ector, page	딍						h	1 🗸 Yes	2 No 1 🔻	Yes 2	No	
tal cian: certif	Be	25. Was case referred to medical examiner?	ospital:				Other Nurs		Residence 6	Other Cases		
n of Vital Recing Physician: The After this certificate funeral director, page	၉	1 V Yes 2 No 27. Manner of Death	28a Date of Injury	1 28	NOutpatient 3		ury at Work?	•	now injury occurred			
Division of Vital Records, ria to Attending Physician: The law requir is after death. al Director: After this certificate has been sed in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	<u>ë</u>	1 Natural 5 Pending	FOUND: Day, Year) F	OUND:	,	Yes 2 ✓ No	Subject ass				
isior Attencer death rector: by the	icat	2 Accident Investigation	28e Place of Injury		501 hrs e, farm, street,	factory, office	building, etc.		Street and Number		umber, City	
Div	ertification:	3 Suicide 6 Could not be determined		d: inside	car trunk			or Town, S 105 West Lak	tate) e Blvd., Prince F	rederick, MD		
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	O	29a. Certifier 1 Certifying Physicia	an: To the best of my ki	nowledge,	death occurred	at the time, o	date and place, a	nd due to the caus	e(s) and manner as	stated.		
To the omple	edical	one) 2 Medical Examiner:	On the basis of examin and manner stated.	ation and/	or investigation			d at the time, date				
	Σ	29b. Signature and title of certifier	5				se number		29d. Date signed		ar)	
		yuss -				O.C	.M.E.		September 2	0, 2007		
3		30. Name and address of person who c				not Dolti	oro MD 242	01				
			nt Medical Examin				ore, MD 212	VI				
St Regis		31. Date filed (Month, Day, Year) SEP 2 8 200		5 9	Spark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18, 2007 4c. County of Death William J. Walker /Medical Sept. 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heights
If Under 24 Hrs. 8. 406 Fawncrest Court Capitol Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑** M 2□ F 84 Yrs. SC Feb. 16, 1923 Director 577-22-1444 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 28a-f show iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director PG Md. Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 406 Fawncrest Court United States

14. Race - American Indian, 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "natural", or i 1 ☐ Yes 2 XNo Specify: Specify. þ 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 Is marked other than "I traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Assistant Train Conductor Amtrak 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Lawrence Walker Mamie Crawford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fawncrest Court Department of Health a Important: If item 27 is any injury or other tra once. Pamela Kenty/daughter 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cem. 9/24/07 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Md. 22. Name end Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Lymphocytic Leukemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1☐Yes 2☐No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

Division or Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: death. within 24 hours after death To the Funeral Director:

20

State Registrar

Certification:

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

September 24, 2007 MD21030

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 Could not be determined

NW. Washington, DC #2151

1 TYes 2 □ No

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

			1 - State of Maryland /	•	artment of F		Mental Hy	giene Reg. No. 2 ()	07 21216
	Physic		1. Decedent's Name (First, Middle, Last) Deborah B. West				2. Date of De Month 9/1	eath 2 U	3. Time of Death 11:54am
	/Medica Examine		4a. Facility Name (If not institution, give street and number) 402 Monterey Ave.			polis	h	4c. County of	of Death Arundel
毕	Funeral Director		5. Social Security Number 151-44-5013 6. Sex 1 M XXF 7. Age (In yrs. last 1 M XXF	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bit 4/5/19	50 Year)	Birthplace (State or Foreign Country) PA
22	th the Maryland or 28a-f show a notified at	irector	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo				10g. Citizen of W	10d. Inside City Limits 1 □ Yes 3€3√No /hat Country?
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	402 Monterey Ave. 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed)	6a. Deced	As Decedent of Hif Yes, specify Cuba ☐ Yes XX No I Yes XX No dent's Usual Occup kind of work done DO NOT use retirect	Specify:			
and 2121	d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r traumatic event, the Med	Be	Elementary/Secondary (0-12) College (1-4or 5+) 5+ 17. Father's Name (First, Middle, Last) George R. Bittner	life. L	Teacher	18. Mother's Na		, Maiden Surname	ucation e)
Maryland	permit. Pages 1 and 2 should the Department of Health and Ment Important: If item 27 is marked any injury or other traumatic ence.	오	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street	and Number or R	ural Route Numb		
Baltimore,			20a. Method of Disposition 20b. Place 20b. Place 20ceme 20b. Place 20ceme	e of Dispos etery, cren	sition (Name of matory or other place ematory	ce)	Date 4/2007		City or Town, State
Balt			21. Signature of Funeral Service Licensee	1.2	2. Name and Address 2 Ridgely	Ave. An	napolis	, MD 2140	Home, P.A. 01
8760,	Physician and Examiner the pnual-transit	dical Examiner	23a. Part : Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the conditio	ce of):		g, such as cardia		irrest,	Approximate Interval Between Onset and Death
P.O. Box 68	ath certifi attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3□	Ectopic pregnancy	,		23d. Date Mor	e of delivery nth Day Year
Records, P	w requires that the defect signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did	4	ribute to the cause of death? 3 ☐ Probably 4 ☐Unknown
al Rec	The law ate has by	Completed by					1□ Yes	psy pormed? d 21 No 1	Were autopsy findings available prior to completion of cause of leath? ☐ Yes 2☐ No
Division or Vital	vttending Physician: death. ctor: After this certifi y the funeral director	Certification: To Be	1	b. Time of Injury	f 28c. Injur Wor M 1 🗀	er: 4 ☐ Nursing I	28d. Describe	idence 6 Other	
Ö	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 ☐ Homicide determined building, etc. (Specify) 29a. Certifier (Check only	dge, death	n occurred at the tir	me, date and plac	e, and due to the	e cause(s) and man	nner as stated.
	To the I	Medical Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	a) (Type,	29c. Licens	e number 5914	15	29d. Date signed	i (Month, Day, Year)
	Sta Regist		Charles Boice, M.D. 2001 Medical 31. Date filed (Month, Day, Year) SEP 13 2007	,		napolis,	MD 2140)1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 10:40 P[™] Marion M. Winters 8. 2007 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 1 F 91 468-10-6686 April 2, 1916 Minnesota Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 □ No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8315 N. Brook Lan# 404 20014 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes Ž No Specify Specify. þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other than any Injury or other traumatic event, the once. Program Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George McReynolds Christine 01son 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Swoope / P.O.A. 3010 Taylor Makenzye CT. Oak Hill, Va. 20171 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oct. 4, 07 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. While ! 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest 5 Minutes Due to (or as a consequence of): Multi-organ Failure Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of) Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by

Physician /Medical Examiner

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Physiclan:

certificate

After this

To the Hospital or Attendi within 24 hours after death.
To the Funeral Director; A completely filled in by the fu

12

death.

funeral director,

ပ

Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Myocardiopathy perforn 1 26. Place of Death (Check only one) Be

25. Was case referred to medical examiner? Assisted Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Living 1 ☐ Yes 2K No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 🛛 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

1 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of/certifier

Year)

29c. License number

29d. Date signed (Month, Day, Year) Sept. 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli MD 10810 Darnestown Rd. Gaithersburg, MD 20878 31. Date filed (Month, Da

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILLIAMS Month **Physician** 830 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore Future Care Nursing Center** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🗙 F 212-22-7418 83 Maryland Aug 7, 1924 Usual Residence of Decedent 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 North Fulton Ave. 21229 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Black, White, etc. Affiled Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store Seamstress 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Keemer Luther Freeland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbert H. Freeland /Son 109 Norman Avenue Glen Burnie, MD 21060 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Plum Point UM Church Cemetery 09/15/07 Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensees 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 9☐ Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes performed 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient No No Other: Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 1 any lijury or other traumatic event. Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or items 23a

death with the Maryland

signed by t page 2 s certificate After this within 24 hours after death

To the Funeral Directors,
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by Be 2 Medical Certification:

State Registrar

29b. Signature and title of certifier

Manner of Death

5 ☐ Pending investigation

6 Could not be determined

Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

one)

4 Homicide

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Baltimne MD 2/20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-EUTOW

28a. Date of Injury

(Month, Day Year)

31. Date filed (Month, Day, Year) 3

32. Registrar's Signature porte

07-07009 Yvonne Wilbekin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

vonne vviibekin		- For State	o / Department of H Certificate of D			No. 200	7 3131
Physician		egistrar I. Decedent's Name (First, Middle,Last)			Reg 2. Date of Death	.110.	3. Time of Death
Medical Examine		Yvonne Ursul	a Wilbekin		Month [September		1415 hrs
		ta. Facility Name (if not institution, give street and numb	· ·	City, Town, or Location of D Salisbury	eath	4c. County of Death Wicomico	
5		Peninsula Regional Medical Center 5. Social Security Number 6. Sex 7.		f Under 1 Year If Under 2	4Hrs 8. Date of Birth	(MM/DD/YYYY) 9. Birl	hplace (State or
Funeral Director		217-74-2030 1 M 2xF		Months Days Hours	Min.	Foreig	
any	ŀ	Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
* .	٦	MD Wicomico	Hebron				1 Yes 2 X No
Maryland 28a-f show d at once,	Director	Oe. Street and Number	11	Of. Zip Code	. 10g	g. Citizen of What Cour	ntry?
h the N 3a or		8050 Levin Dashiell Road		21830	1 -	USA	
death with the Maryland or items 23a or 28a-f sho	Funeral	11. Marital Status 12. Was Deced 1 Never Married 2 Married Armed Force	ent Ever in U.S. 13. Was D es? If Yes,	ecedent of Hispanic Origin' specify Cuban, Mexican, Po	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
er dea		1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	es 2 X No specify:		Specify: Bla	ıck
urs af itural' amino	d by	15. Decedent's Education (Specify only highest grade	completed) 16a. Decedent's	Usual Occupation (Give kin	d of work done	16b. Kind of Business/	
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she Ib: M. dical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4	or 5+) during most	of working life. DO NOT us	e retired)	77.77	
15-003 filed within Hygiene. d other the		2	USDA I	nspector	Name (First, Middle, Ma	Allen's Fa	rms
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) John Arthur Giddens, Jr			ene Price	alderi Samame)	
D 21218 should be fill and Mental H 7 is marked natic event, I		19a. Informant's Name/Relationship (Type, Print)		ddress (Street and Number		er, City or Town, State	, Zip Code)
MD ad 2 shoulth and m 27 is aumati		Anthony Giddens/Brother		entral Avenue			
# E E E		20a. Method of Disposition 1 x Burial 2 Cremation 3 Removal from	20b. Place of Dispositio crematory or other	n (Name of cemetery, place) Gardens	Date 2007	20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other Specify:	Springhill	Memory S	Sept. 9,	Hebron, Ma	ryland
Baltimore permit. Pages 1 Department of F Important: If injury or other	V	21 Signature of Funeral Service License	0	e and Address of Facility ey Memorial Cha	Salisbury,		ad 21801
Physician		23a. Part I. Enter the disease, or complications that cau	sed the leath. Do not enter the	mode of dying, such as card	liac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each lipe. Immediate Cause (Final disease a. Multiple Injur		Death			
Adminion		or condition resulting in death) Due to (or as a co	onsequence of):		•		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a co	onsequence of):				
	Examiner	(Disease or injury that initiated	onsequence of):				
ured nd ransit	Ĕ	events resulting in death) Last Due to (or as a condition of the condition					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implicely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED					
760, icate be g physici the buri		IF FEMALE: 23c. If yes, ou 1 Live birt	tcome of pregnancy	S Estania n	roenancy	23d. Date of deliver Month	y Day Year
Box 687 death certific the attending p	Physician/	past 12 months?	2	death 3 Ectopic p	regnancy	World	Day real
BO) e death the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknow	'n				
that the d ned by the detached	by P	Part II. Other significant conditions contributing to c	leath but not resulting in the und	erlying cause given in Part		eacco use contribute to 2 ✓ No 3 Pro	
Division of Vital Records, P.O. tal or stending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	ted				24a. Was a		utopsy findings available
cords, law requir has been s	Completed			- "	autops perform	y prior to	completion of cause of
tal Re(inn: The certificate		OF Management to modify		26.Place of Death (C	1 Yes 2	No 1 ✓ Y	es 2 No
Vital Rec ysician: The l his certificate	o Be	25. Was case referred to medical examiner? Hospital: 1 Inc.	patient 2 🗸 ER/Outpatient 3	Other		Residence 6 Othe	r:
ing Phy After th	-	1 V Yes 2 No 28a. Date of (Month D	Injury 28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe he Driver auto a	ow injury occurred	
ion tendir eath. tor: A	atio	1 Natural 5 Pending Sep 9, 20 2 ✓ Accident Investigation	1354 hrs	1 Yes 2 V N	0		
Divisior pital or Attencours after death neral Director:	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, street,	factory, office building, etc.	or Town, Sta	ate)	ural Route Number, City
D Hospital 24 hours Funeral			Major Road / Highway	d at the time date and along		Lillian, Hebron, MD	and a
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a. Certifier (Check only one) Certifying Physician: To the best one) 2 Medical Examiner: On the basis of	examination and/or investigation	, in my opinion, death occu	rred at the time, date a	nd place, and due to the	ne cause(s)
To with	Mec	and manner sta 29b. Signature and title of certifier	led.	29c. License number		29d. Date signed (Mo	onth, Day, Year)
11		Muna Brasal M	<u> </u>	O.C.M.E.		September 10, 2	2007
Su		30. Name and address of person who completed cause		0, , , , , , , , , , , ,	MD 04004		
		Melissa Brassell, MD Assistant Medi	ical Examiner 111 Per	nn Street, Baltimore,	IVID 21201		
St Regis	tate trar	on Date med (Month, way, mark, 2007	low of Joan				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ARN ININE 3°0 0410 M **Physician** USSELL 0 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Mandarin Hospice House Harwood 6. Sex 1 2 2 F 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 5/15/1946 Months Days Hours Min. 519-52-3447 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 28a-f show at 1 ☐ Yes 2X No ed other than "natural", or items 23a or 28a-f sleent, the Medical Examiner must be notified Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 929 Genine Drive filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖁 No Specify: white Baltimore, Maryland 21215-0036 Specify. 5 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Dept. of Defense Security Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi Flaherty Olive permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic ev Henry Bogess Arnwine ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 929 Genine Dr. Glen Burnie MD 21060 Mrs Bejetta J Arnwine / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 10/4/2007 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Srvc 21. Signature of Fundal Soviet Licen M01364 1 2nd Ave SW Glen Burnie MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final ren **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2□ No certificate 2 No 1 ☐ Yes or Attending Physiclan; 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Hospital Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29b. Signature and title of certifie

Registrar

State

Name and address of person who

Year)

2007

01

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19a per INF C872 10/11/07 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 28,2007 Month **Physician** 9:00P M September Charles Wayne Agness /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9202 Log Chain Road Columbia Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠**M 2□ F 85 295-18-9232 Aug. 29,1922 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21045 U.S.A. 9202 Log Chain Road "natural", or items 23a by Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Central News Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leola Fischer Claude Agness ပ 19a. Informant's Name/Relationship (Type. Rrint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Log Chain Road Columbia, MD 21045 Joyce Agness 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosehill Burial Park: 10-3-2007 Fairlawn, Ohio 21. Signature of Funeral Service Lidensee 02010M Witzke Funeral Homes, Inc. Sma 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mo TIC cm1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician requires that the death certificate be Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Iniurv 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE PFOXEINE 11355 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

OCT 0 1 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

7:43 A_M Ellis C. Alston 23 2007 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day. **Funeral** Months Days Hours 1**X** M 2□ F Yrs 86 31 1920 Warrenton, NC 232-30-4824 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Prince George's Forestville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 2514 Kirtland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Truck Driver Government Pages 1 and 2 should be filed vent of Health and Mental Hygis int: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mansfield Alston Hattie Mae Alston ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lizzie Mae Alston/Wife 2514 Kirtland Avenue, Forestville, Maryland 20747 Date 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □Donation 5 □ Other (Spegiff) Aug 31 2007 Cheltenham, Maryland Maryland Veterans 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Vicensee 101085 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** 101114-/Medical Due to (or as a consequence of): Examiner ve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ Nor 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 1□ Yes spital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 XER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08/23/07 LON D64055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric McDonald, 7503 Surratts Road, Clinton, Maryland 20735 31. Date filed (Month, Day, Year) gistrar's Signature State OCT 0 1

Registrar DHMH 17 Rev 1/2001

The law requires that the death certificate be executed use as the burial-transit and attending physician Division of Vital Records, P.O. Box 68760 2 certificate has been signed I rector, page 2 should be det this After thi

SID, Mahamma

State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:45 PM **Physician** 2007 Muhammad Asin /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore tranklin 7. Age (In 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) last birthday) **Funeral** Days Min. Months Hours 1 ☑ M 2 □ F Director none Sept 20, 2007 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Harford Abingdon 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ö 3265 Meadow Valley Drive 21009 USA or Itame 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: white ģ 3 Widowed 4 Divorced Year or Dates: ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) none none none unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zeeba Zaman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Franklin Square Drive Baltimore, MD Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ▼Other (Specify) in state 21. Signature of Euneral Service Ronald State Anatomy Board 655 W. Baltimore Street Dixector enne 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 ☐ Yes 2 No 1 Tyes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident filled in by the Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 00000 30. Name and add completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, md 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 1 2007 Comment. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Barter Rosetta September 22, 2007 2220 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayniew Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur NA Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Markhal Davis Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 213-32-3755 February 9, 1936 MI Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 21205 2831 Ashland Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Media-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) honemaker 12th grade home maker none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ohn Lewis Garette Sarah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2831 Ashland Ave. Baltimore MD 21205 David Bartle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2007 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE CUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myocardial 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl performed? 1☐ Yes 2☑ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fr 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -000

State Registrar

DHMH 17 Rev 1/2001

4940 Easten Ave Bultimore Maryland 21224

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grant Chow MD

OCT 0 1 2007

31. Date filed (Month, Day, Year)

Eldridge Battle		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2017 3132							
Physicia		1. Decedent's Name (First, Middle,Last) Hidred L. Battle		2. Date of Death	. No. 200	3. Time of Death			
Wedical Examine		Eldadon Buthla	Month September	Day Year 22, 2007	0245 hrs				
		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death	1.4.			
		1813 North Chester Street	Baltimore	1.1	\wedge	I/A			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Bir				
Director		218-70-8318 17M 2 F 5/ Yrs.	Months Days Hours Min.	11-05	5-1955 Foreig	untry) Mds			
	ŀ	Usual Residence of Decedent		1					
any		10a. State 10b. County 10c. City, Town or Location	,			10d. Inside City Limits			
nd show	닐	ma, N/A Balt	rmore			1 Yes 2 No			
Maryland 28a-f show datonce,	Director		Of. Zip Code	109	g. Citizen of What Cou	ntry?			
ith the Maryland 23a or 28a-f sho notified at once.		2143 Chelsea Terrace	21216		US	A			
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral		ecedent of Hispanic Origin? (Sp			ican Indian, Black,			
death rr iter	Š	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	3 lack			
after	by	or Dates:	s 2 No specify:		Specify:	SIACK			
)36 thin 72 hours : te than "naturs edical Exami		during most	Jsual Occupation (Give kind of vortion of working life. DO NOT use reti		16b. Kind of Business/	and the second			
2 3	Set	Elementary/Secondary (0-12) College (1-4 or 5+)	sever work		N/	A			
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		17. Father's Name (First, Middle, Last)	Gener	(First, Middle, M	. /				
2121 ould be fin marked c event,	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	Idress (Street and Number or I		er City or Town State				
and sho		Donise Battle - Sister 1362	Walker Ave	_	oimdi 2				
and 2 Health tem 2 traun		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City or				
Baltimore Department of He Important: If it injury or other t		1 Burial 2 Cremation 3 Removal from State Crematory or other 4 Donation 5 Other Specific		29-07	Pikesville	e, mf,			
Baltim	-	4 Donation 5 Other Specify: 21. Sign and of Funer IS vice stansee 22. Nam	- /		1 Desville	Pass			
Balt permit Depart Impor injury		Carlotte Car	e and Address of Facility 2	o mea	HILTON	cerb, und, 21229			
Physician		23a Dant I Men the disease, or complications that caused the death. Do not enter the n				Approximate Interval			
/Medical	8 14	failu e List only one cause on each line. Imme tiate Cause (Final disease a Smoke Inhalation				Between Onset and Death			
zaminer		Imme fiate Cause (Final disease or condition resulting in death) a. SMOKE INNAIATION Due to (or as a consequence of):							
		Sequentially list conditions, b							
	ie	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
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60, ate be ohysici ne buri		#1, DETYE, g072, 10/2/07 11 IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	y			
687 ertific ding p	au/	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregna	ancy		Day Year			
Box 6876(death certificate the attending physical for use as the b	sici	4 Pregnant at time of death 5 Other 1 Yes 2 No 9 Unknown g Unknown	(Specify)						
ires that the de signed by the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I	23e. Did tob	pacco use contribute to	the cause of death?			
P.O. es that the igned by be detacl	þ	Tark to death of the control of the	strying codes given in that i.			bably 4 Unknown			
ords, w require is been sig should b	ted			24a. Was a	n 24b. Were a	utopsy findings available			
COFC law re has be	휥			autops	y prior to	completion of cause of			
Rec The licate	Completed			1 Yes 2		es 2 No			
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be (25. Was case referred to medical examiner? Hospital: I legation: 3 EP/Outpation: 3	26.Place of Death (Check						
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n of ding P After funera	흥	27. Manner of Death 1 Natural 5 Pending Sep 22, 2007 28a. Date of Injury Sep 22, 2007 28b. Time of Injury 0145 hrs	y 28c. Injury at Work? 1 Yes 2 ✓ No	Victim of hou	ow injury occurred ISE fire				
Sion Viten death cetor:	gati	2 Accident Investigation		005 1 1 1 10	D. D. D.	B. A. N. A. C.			
lor /	Certification:	3 Suicide 6 Could not be determined (Specify) Townbourse / Powthouse	actory, office building, etc.	or Town, St	ate)	ural Route Number, City			
Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide Townhouse / Nowthouse		L	ester Street, Baltime				
Division of Vital Records, P.O. Box 68760 within 24 hours afterding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	check only one) 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation							
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth. Dav. Year)			
		in his my	O.C.M.E.		September 22, 2	,			
					,				
}		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201			-			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary 200, Portugation of the action of the state of Mary 1200 of the state 31325 Certificate of Death 1. Decedent's Name (First, Middle, Last) MARY BRANNON 2. Date of Death Days/t Month 200 T **Physician** 12.52 PM Dentervier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BA 5. Social Security Number Year If Under 24 Hrs. Days Hours Min. South GREEN If Under 1 Year 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 216-20-5658 1 □ M 2 2 F Director JANUARY 8, 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 □ No Director BAIT, more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Suth GREEN U.S.A 3208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other trainmant. 12 th gende 4415 TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson MAGGIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Rd MAKY KAndellstaan MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCT2 12 Burial 2 Cremation 3 ☐ Removal from State # 2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home BeTTS alread ARdline ST. BAHTMO 23a. Punt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Mol Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (r s a consequence) 4000 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed peen s 24a. Was an autopsy performed? 1∐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No certificate has page 2 2**X** No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death. the Funeral Director; mpletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 24 and manner stated. To the within 2 29c. License number D 30 66 / 29d. Date signed, (Month, Day, Year) September 26 th 2007 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 28a) (Type, Pont) 31. Date filed (Month, Day, Year) QCT 0 1 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:00 Am 09 Lorraine K. Box 28 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 12-29-1934 Director 029-28-3033 MA Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2/ ☐ No Director Severn Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7980 Old Telegraph Road 21144 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Terrance Edward Kelly Ellen Earner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Mr. Jimmy D. Box / Husband 7980 Old Telegraph Road <u>Severn, MD 21144</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 10-02-2007 | Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee 1 2nd Ave SW Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kenal Cell Concinona **Physician** letastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 000 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe certificate 2. No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 Yes 2 No L L 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation the Funeral Director: npletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

within 24 }

4 Homicide

29b. Signature and title of certifier

000A 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

900

32 Registrar's Signature

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** mes arter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NIA Nursine altemore ttaven If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 315-14-5123 Director 30,1922 Marylang man Usual Residence of Decedent 10c. City, Town or Location 28a-f show notified at 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Md. 10e. Street and Number 10g. Citizen of What Country? ms 23a or i 21 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ont: If Item 27 Is marked other than "natural", or items 23s ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 211No Blac 1 ☐ Yes 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natul any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Iruckina 12-16 NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be Stan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Care Baltonie Giver 2700 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Owing MILLS, MD, Forest Oct. 2, 2007 4 Donation 5 Dother (Specify) 21. Signature of uneral Servic Licens 22. Name and Address of Facility 270 FredHILTON Palas do, md, 2,229 P. march Fringral Home 23a. Party Ent / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2.2 No

P.O. Box 68760, After this certificate has been signed I funeral director, page 2 should be det Division or Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Be Certification: To

7

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐ Could not be

1 ☐ Yes 2 🗖 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

32 Registrar's Signature

9-28-07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Gorale)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			Fieas 1 - State Registrar	State of Ma		d / Depa		Health and I	Mental Hy			31328
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, 4a. Fecility Name (If not institution, g FT. WASHINGTON H	give street and number)	С.,	CEN.	4b. City, Town, o	or Location of Death HINGTON	2. Date of De Month	Day 4c. Cou	Year O 7 unty of Death CE GE(
	Funeral Director		5. Social Security Number 088-30-4360 Usual Residence of Decedent	. Sex 7. Ag 1□M 2ĂF		ast birthday) 70 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da JULY 1	th 17. Year) 5, 193	9. Birth Cou	place (State or Foreign intry) ISBURGH, Pa
	e Maryland a-f show	ctor	10a. State 10b. County DC			Town or Lo						10d. Inside City Limits 1 ⚠Yes 2 ☐ No
	with th	al Dire	10e. Street and Number 1905 ROSEDALE DT	., N.E. #3			10f. Zip Code 20002			10g. Citizen UNITE	of What Cou	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Example at Intert to Incitited at	by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 SYes 2 If Yes, Give Year or Dates:	No	1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))	Race - Amer Black, White ecify: BLZ	, etc.
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212	od withii giene. er than	Somp	Elementary/Secondary (0-12)	College (1-4ors 1Yr	5+)	,,,,,		OGRAPHER		P	HOTOGE	RAPHY
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, I a M	To Be (17. Father's Name (First, Middle, La JOHN CLARK			,		18. Mother's Nan		, Maiden Sur	name)	
Mar	d 2 should and the modern of t		19a. Informant's Name/Relationship STORM CLARK/DAUG					and Number or Ru				
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: if item 27 is any injury or other tra ange.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		20b. PI	ace of Dispo	esition (Name of matory or other pla	ER DR,	Date WAS		on - City or T	
Itim	it. Pag rtment rtant: I		*4 Donation 5 Other (Spe	city)	CHE		KE CREMA		1/0/	BELTS	VILLE,	MD. D.C. 20002
Bal	permi Depe Impo any is		21. Signature of Funeral Service Like	1 4137 J. J.	lli		2. Name and Addre APITOL M	•	425 MAR	YLAND	AVE.,	N.E. WASH.
68760,	Cate be executed hydrogram and physician and physician and the burial-transit sthe burial-transit	dicai Examiner	23a. Part1. Enter the disease or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as d	a conseque a conseque	rence of):	nler	to be		Venr	4	Approximate Interval Between Priset and Death
P.O. Box 6	Hospital or Attending Physician: The law requires that the death certificate the nours effer death. Funeral Director: After this certificate hes been signed by the attending phy tely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 90℃ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 953 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		23d.	Date of delive	v ery Day Year
rds, P	quires that It n signed by uld be detac	d by Pt	Part II. Other significant condition:	s contributing to death b	ut not resu	iting in the u	nderlying cause gi	ven in Part I.		obacco use o		the cause of death?
Division of Vital Records,	: The law requir cate hes been si , page 2 should	Completed by					,,,,,		24a. Was auto perfo 1 Yes	an 24 psy prmed? 2.22No	b. Were aut prior to or death? 1 Yes	opsy findings available ompletion of cause of 28 No
Vita	ysician is certif director	To Be	25. Was case relerred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatier	at 3□ DOA D#	28. Place of Dea	th <i>(Check only c</i> ome 5 ☐ Resi		Other (Spec	itv)
o u	ing Ph	l :uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wo		28d. Describe	how injury oc	curred	
Divisio	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determina	be	ury - At hor c. (Specify	me, farm, str	M 1 C]Yes 2□No	28f. Location (City or To	Street and Ni wn, State)	umber or Rui	ral Route Number,
	he Hospite n 24 hours he Funeral pletely filte	Medicai C		Physician: To the best aminer: On the basis of and manner sta	f examinati							
	To the within 2 To the complete	Σ	29b. Signature and title of certifier		>	_	29c. Licens	se number	-	29d. Date sig		•
	\sim		30. Name and address of person wh	no completed cause of d	eath (Item	23a) (Type.		0437	7	09,	28,0	+
	D		LAXIMI N. BERWA	MD., 770	0 OLI	D BRAN		SUITE C-	101 CLI	NTON,	MD. 20)735
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 1	2007 32. Patistr	ars Signat	ure & A	and I					

DHMH 17 Rev 1/2001

07-07215 Alexis Caston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31329

		1- For State Registrar				Cer	rtificate d	of De	ath					Reg. N	ю.		
Physicia edical Exami	in/	1. Decedent's Name		ASTON									Date of De Month Septemb	Day	y Year 5, 2007		3. Time of Death 1949 hrs
	ı	4a. Facility Name (i				ımber)		1	ity, Town, inton	or Lo	ocation of	Death	(I) (a)(1)		4c. County o Prince G		s
Funeral Director		5. Social Security N	lumberUNK		1 2 F	7. Age (In yrs. I	22	_ <u> </u>	Under 1 Y	ear Oays	If Under Hours	Min	8. Date of B			Foreign	place (State or ntry) WASH., DC
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intition 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be antified at once.	Be Completed by Funeral Director	11. Marital Status 1 X Never Marri 3 Widowed 15. Decedent's Edementary/Sect 1.7. Father's Name FLOYD Ca	PRINCI mber LARK S' ed 2 M 4 Div ducation (Spe ondary (0-12) 2-th (First, Middle ASTON	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No orced If Yes, Give Year or Dates: College (1-4 or 5+) Last)			Town or Loc PITOL F S. 13. V If 16a. Deced during	HE IC 10f 2 2 Yes, s Yes Yes, s Tent's U most o	TRUCK DRIVER 10f. Zip Code 20743 20743 20743 20743 20743 20743 20745 20					white, etc. Specify: BL rk done 16b. Kind of Business, TRUCKING First, Middle, Maiden Surname) CASTON			10d. Inside City Limits 1 X Yes 2 No No PES an Indian, Black, CK
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other if injury or other traumatic event, the Med	То	19a. Informant's Na FLOYD CZ 20a. Method of Dis 1 Burial 2 4 Donation 5 21. Signature of Full Sign	ASTON/I	FATH oecify: License	Removal for search and	rom State CEI	Place of Disp crematory or DAR HII	oosition other pLL C. Name	CARK (Name of place) CEMET and Add	ST ceme ER ress of	CAT etery, Y of Facility RTUAF	9/2!	L HEIO Date 5/07 425 MZ	GHT:		207 City or ND , C	Fown, State
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medical Examiner	Immediate Cause or condition resulti Sequentially list co if any, leading to ir cause. Enter Und (Disease or injury events resulting in VINPENDED IF FEMALE: 23b. Was decedent past 12 month	(Final Isease ng in death) conditions, mmediate erlying Cause that initiated death) Last pregnant in to s?	a	Cardiac ue to (or as a AMENDED #23a&b 23c. If yes, 1Live	a consequence of present at time of drawn	of): Atheroclicated licated of): of	by rME,	gitat g873,	ed 11/	behav	ior w	hile b	ease	Phenomena Phenom	ined	
cords, P.O. aw requires that the mas been signed by 2 should be detach	Completed by Ph	Part II. Other sign		tions (contributing	to death but not	resulting in th	e unde	rlying cau	ise giv	en in Par	t I.	1 24a. W au	Yes 2	2 No 3	Prob	the cause of death? Pably 4 Unknown Topsy findings available completion of cause of
tal Rec tian: The l certificate l		25. Was case refe	rred to medica	- T					26.F	lace o	of Death (Check or	1 Ye	s 2	No 1	✓ Ye	s 2 No
Vital I hysician: this certifial director,	То Ве	examiner? 1 ✓ Yes	2 No		ospital: 1	Inpatient 2					Other 4		Home 5		sidence 6	Other	: :
Sion vttendi death. ctor: /	Certification: To	27. Manner of Dea 1 Natural 2 Accident	5 Pen	ding estigation	9/16/	e of Injury th, Day,Year) /2007 ce of Injury - At I	28b. Time of 7:00 p	.m.	1[Ye	at Work? es 2 X	No S	amily	deat memb	ers	g res	straint by
Divi Hospital or 24 hours afte Funeral Dir cely filled in								curred	at the tim	e, dat	e and pla	ce, and c	due to the c	ark ^{ause(s}	St. Cap) and manne	r as state	Heights, MD
To the Hos within 24 h To the Fur completely	Medical	one) 2	_		On the basis and manner	of examination stated.	and/or investi	igation,				curred at	the time, da				
	Σ	29b. Signature and	d title of certifi	er W	, ν	WP				.C.N	number 1.E.				eq. Date sign Septembe	,	nth, Day, Year)
JOK BUN		30. Name and add			edical Exa		^{m 23a)} 1 Penn Str	reet, I	Baltimo	re, N	/ID 212	01					
S Regis	tate		nth, Day, Year,	200	32.	egistrar's Signa	ture	and a	2)								
			161 U -	DHMH 17 Rev 1/2001 OCASE ORIGINAL													

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Lizeta Cheirdari

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

September 28,

Day

2007

2:30 A M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** D M Carric Georgia 2007 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore

9. Birthplace (State or Foreign Country)

Country)

A Dundalk Road Builneck 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖼 F Days Year) Min 24 4514 220 Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? allneck U.SA 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If Item 27 Is marked other than "natural", or Ite 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HomeMaker OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Edward dNEW TORIO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bullneck Dundalk, MD 21222 Depertment of Health mportant: if item 27 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State -21-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I Kensee radley - Askton Funcial Home, Spring Rd 2134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral by arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 2 No 1□ Yes To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Yes 2 PMNo Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 ☐ Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 18, 2007 035763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cordts 5505 Hopkins Bayview Circle Baltimore, Md 21724 mo

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma		Certificate of L			aeg. No. 20	07 3	313	32
	Physicia	an .	1. Decedent's Name (First, Middle					2. Date of Dea Month	Day	Year 0	Time of De	eath P M
	/Medic	al	Stanley James 4a. Facility Name (If not institution			4b, City, Town, or	Location of Death	August	30 2 4c. County	2007		
	Examin	er	Washington Adv		tal	Takoma Park Montgomery						
	uneral irector		5. Social Security Number 578-68-8604	6. Sex 7. Age 1	(In yrs. last birth	day) if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 1,	, Year)	9. Birthplace Country) Washin		
faryland	show ed at	or	Usual Residence of Decedent 10a. State 10b. County DC		10c. City, Town	or Location .ngton			10d. Inside City Limits 1X Yes 2 □ No			
the N	28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?		
n with	3a or st be	al Di	1342 Pennsylva	nia Avenue,	SE	20003-	-3037		United	d State	s	
2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental rhygene. Important: If them ZT is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)	Blac	e - American In k, White, etc.		_
72 ho	natur dical	eted	15. Deceden (Specify only highe	t's Education st grade completed)	16a. [Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of wor	king	16b. Kind of Bu	usiness/Industry	У	
ithin '	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ito Mechani			Pr	ivate		
filed	Hygie ther t		17. Father's Name (First, Middle,	Last)	A	Teo neemani	18. Mother's Nan	ne (First, Middle,				
d be	ked o	To Be	Clarence B. (Collins			Mar	ie Green				,
shou	and M s mar sumat		19a. Informant's Name/Relations			Mailing Address (Street						J.
and 2	n 27 I		Crystal Coll:	ins/Daughter		Girard St		, Washin	gton, Do			
ges 1	or oth		20a. Method of Disposition 1 Burial 2 Cremation			Disposition (Name of crematory or other place		1/2007		le, Vir		2
mit. Pages	ntmer njury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Quan	tico Nation 22. Name and Addre	1 .					2
Per D	Impor any Ir		Antt G	Arm MUIN	35	5538 Marlb	oro Pike	, Forest	ville,			747
H			23a. Party. Enter the disease of shock or heart failure. List	complications that caused tonly one cause on each li	the death. Do no	ot enter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Apr	proximate erval Betwe set and De	een
Ph	ysician		Immediate Cause (Final disease or condition	Athe	vosche	rolic Ca	vdious	culas c	Lices		set and De	auri
	Medical aminer		resulting in death)	Due to (or as	a consequence of	f):						
_^	ammer	_	Sequentially list conditions,		e psi							
rted	nsit	Examiner	Sequentially list conditions, if any, feading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Accu	ived	Immuro	dofice.	aup S	fudro.	me		
exect	in and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence o	f):		1	t			
50/50 , tificate be executed	nysicia he bur	edical 1		d								
	ing ph e as tl		IF FEMALE:	23c, if yes, outcome	of prognoncy				004 Da	ate of delivery		
OrdS, P.O. DOX requires that the death cer	he attend led for us	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			onth Day	y Ye	ear
that th	ed by detacl		Part II. Other significant condit	ions contributing to death b	ut not resulting in	the underlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to the ca	ause of de	ath?
COLOS, w requires	n sign	d by						1 🗆	Yes 2 No	3 Probably	/ 4 □Ur	nknown
Tec	certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Completed						24a. Was auto perfi 1 Yes	psy ormed?	Were autopsy prior to comple death?	findings a etion of car	vailable use of
VITAI ician:	ertifica ector,	Be C	25. Was case referred to medical examiner?				205	ath (Check only				
Or V	this or	은	1 ☐ Yes 2 ☐ No	Hospital: 1 Impati		patient 3 DOA			idence 6 Otl			
on C	h. After funera	ion:	1 Natural 5 Pendi	(Month D		njury Wo	rk?]Yes 2∏No	20d. Describe	now injury occur	1100		
DIVISION OF VITA	after death Director: I in by the	Certification:	3 Suicide 6 Could	not be 28e, Place of in	jury - At home, far tc. <i>(Specify)</i>	rm, street, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rural Ro	oute Numb	per,
Sta Sta	within 24 hours after of To the Funeral Direct completely filled in by	Medical Co	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best if Examiner: On the basis of and manner s	of examination and	, death occurred at the t d/or investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and m	nanner as state , and due to the	d. e cause(s))
To the	within To th compl.	Me	29b. Signature and title of certifi				se number		29d. Date signe			ميد
) [1	MD		DO	06010	00	4	_ 09	-21	27
_0	7		30. Name and address of person	11 14ME	~	Type, Print)	Vis SP	ritersii	MBL.	2090	3	
	St Regist	ate rar	31. Date filed (Monty Pay Yea	1 2007 32. Ggist	rar's Signature	Spelle						

State

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar

M



toward

wn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C0

Hospital GHIE Patriery Pkny

26,2007

To the Hos within 24 h To the Fun complately
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Sta Registr
DHMH 15 Bey 6/9

	State of Mary	and / Department of Health and I Certificate of Death	Mental Hygiene Reg. No 2007	31334
0	1. Decedent's Neme (First, Middle, Last)	1000	2. Dete of Death Month / Dev Yeer	3. Time of Death
Physician /Medical	Lawrence NO	9504	Sept 27 2007	220
Examiner	4e Fecility Neme (If net institution, give street end number)	4b. City, Town, or		CONTE
	5. Social Security Number 6. Sex 7. Age (In	yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth 9 Birth	polace (State or Foreign
Funeral Director	220-26-2630 XX ^M ^{2□} F 74	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) July 7, 1933 9. Birth Cou	nplace (State or Foreign intry) cyland
	Usuel Residence of Decedent			
or 28a-f show		City, Town or Location		10d. Inside City Limits
vith the Maryle or 28a-f sho be notified at	2 2	Burtonsville 10f. Zip Code	40- Ciki 414/ 400-	1 Yes 2 No
with with Dir	10e. Street end Number 4404 Sandy Spring Road	20866	10g. Citizen of What Cou	nitry r
fler death w r flems 23a iner must Funeral	11. Marital Stetus 12. Was Decedent Ever	in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - Ameri	
or itter	Armed Forces? 1 Never Married 2 Married 1 1 Never Married 2 No	If Yes, specify Cuban, Mexican, Puerl		
ours a	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	TEL TES ZEENNO Specify.	Specity: Whi	
ed within 72 hor ygiene. Nor than "natura nt, the Medical E	15. Decedent's Education (Specify only highest grede completed)	16e. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)	king 16b. Kind of Business/ir	ndustry
withir ene. than	Elementery/Secondery (0-12) College (1-4or 5+) Grade 9	Truck Driver	Transporta	ation
be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or thems 23a or 28a-f show avent, the Medical Examinat must be notified at avent, the Medical Examinat must be notified at Be Completed by Funeral Director	17. Fether's Neme (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Maiden Surname)	
Menta Menta Mrked arked To B	John William Dodson	Elsie B	rown	
2 should and Men la marke aumatic	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Ru		
and sealth m 27 her tr	Nellie May Dodson / spouse	4404 Sandy Spring Roa		
Deportment of Health and 2 should be filed within apportant: If Item 27 Is marked other than ny Injury or other traumatic avent, the Mones. To Be Comp	20a. Method of Disposition XXX Buriel 2 ☐ Cremation 3 ☐ Removal from State	Ob. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or T	
it. Pe rtmen rtant: njury		Union Cemetery	10/1/07 Burtonsvill	e, Maryland
Depermine any Ir	21. Signature of Funeral Service Licensee M0 0 7	22. Name and Address of Fecility Donaldson Funeral		
		deeth. Do not enter the mode of dying, such as cardiac	Laurel, Maryland	20707 Approximate
Physician	23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on eech line.	John Sing one and a spring out the second	/	Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	cardial into	aution	4 her
Examiner	resulting in death) e. Due	to (or as a consequence of):	1:	11
executed in and ial-transit	a b COV	suavy auter	1 d searc	1045
esta be executed hysician and the burial-transit dical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.	to (or as a consequence of):		
ceta be execut physician and the bunal-tran		(A)		
.0 11 10	Yesulting in death) Last	o (or es a consequence of):		
requires that the death certification signed by the ettending thould be detached for use eseted by Physician/Me	d		1	
s deat he ett ned fo	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute	to the cause of death?
d by the detack	emphreng	7	1 Yes 2□No 3□Pro	obably 4 ☐ Unknown
iras the signed d be d			24a. Was an autopsy 24b. V	Vere autopsy findings
requipenshould			performed? a	available prior to completion of cause of death?
ysician: The law requiris certificata has been si director, paga 2 should			_ ~	Yes 20 No
stan: The strifficate sector, pa	25. Wes case referred to medical	26. Place of De	eth (Check only one)	
Physician: r this certific ral director,	examiner?	Othor:	lome 5 ☐ Residence 6 ☐ Other (Spec	sity)
ng Phys ter this neral di	27. Manner of Death ↑ Naturel 5 □ Pending (Month, Day Yea	28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred	
Attending or death. ctor: After by the fune	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	COM Landing (Charles of Number of D	and Doute Mumber
tal or Attending P rs after death. In Director: Attert led in by the funer: Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (Sp	At home, farm, street, factory, office ecify)	28f. Location (Street and Number or Rus City or Town, State)	rai Houte Number,
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th complately filled in by the funeral Medical Certification:	29a. Certifier Certifying Physician: To the best of my	knowledge, death occurred at the time, date and plece	, and due to the cause(s) and manner es	stated.
fo the Hospital within 24 hours of the Funeral I complately filled Medical Co		nination end/or investigation, in my opinion, death occu		
To the comp	29b. Signature and tifle of certifier	29c. License number	29d. Date signed (Month	
~	· KCOY UNIO	V91617	- Sept ZF	,200/
At 1 T	30. Name end eddress of person who completed cause of death	(Item 23e) (Type, Print) Hickori Ridse Ko	Lolunsia, Ma	2/ Zucii
1 1 1	31. Date filed (Month, Day, Yeer) 32. Resistrer's S	ignature.	1014a019,000	7 21079
State Registrar	31. Date-filed (Month, Day, Yeer) 32. Resistrer's S	St. Aprile	ŕ	

		ľ	1 - For Stete Registrar	State of Marylan		artment of H tificate of L		nd Mental Hy	giene UU / Reg. No.	31333
			1. Decedent's Name (First, Middle, Last					2. Date of De		3. Time of Death
	Physici		Baby Boy Dotson					Senten	1 0 0	1 1 1 1 1 1 1 1
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of	Death	4c. County of De	eath
н		•	The Johns H	ankins Hosk	rital	Bal	timor	re City		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bir	v. Year)	Birthplace (State or Foreign Country)
н	Director		none 19]M 2□F	Yrs.	Wioning Days	Hours 20	Sept	19, 2007	Marýland
	P .		Usual Residence of Decedent	100 0	y. Town or Lo					10d. Inside City Limits
	show	_	10a. State 10b. County		•					1 ☐ Yes 2√ No
	Ba-f	양	MD Charles		Pall M					21
	計 20.20 20.20	Director	10e. Street and Number			10f. Zip Code	2066		10g. Citizen of What	Country?
	ath w	ra	18414 Point Looko				2066		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black, W	merican Indian, hite, etc.
36	d within 72 hours after death with the Maryland Jiene. I then "naturel", or tiems 23s or 28s-f show The Medical Examiraer must be neillfisd at	by F	1 Never Married 2 Married Married 2 Married Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2∭X No	Specify:		Specify: 1	lack
Ş	hour	b t	15. Decedent's Edu	Year or Dates:	16a Dece	ient's Usual Occupa	ation	<u> </u>	16b. Kind of Busine	ss/industry
15	"nat	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	lurina most	of working		<i>-</i>
12	within iene. than "	Ē	Elementary/Secondary (0-12) none I	College (1-4or 5+)	non	.e			none	
9	Hyg The street	ပိ	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle	, Maiden Surname)	
an	o a a	To B	Walter Dots	on			Sh	amika Dots	on	
7	2 should and Men is marke sumatic	_	19a. Informant's Name/Relationship (T)	rpe, Print)					er, City or Town, State	e, Zip Code)
Baltimore, Maryland 21215-0036	nd 2 ilith a 27 ts r tra		The Johns Hopkins	Hospital	600	N. Wolfe	Stre	et Baltimo	re, MD 21	287
ē,	of Health itam 27		20a. Method of Disposition	1 /	Place of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location - City	or Town, State
Ę			1 ☐ Burial 2 ☐ Cremation 3 ☐ F 3 ☐ Cremation 5 ☐ Cremation 3 ☐ F	temoval from State		, ,	1			
Ħ	구두분수		21. Squatture of Fundant Sprice Licens	460	. S ²	Name and Address	Sin Faggie	sard 655 W.	Baltimore	Street
ñ	permi Depar Impo any ir	ti e	Konard 31	Ville Con		ltimore,	-	21201		
			23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o	ications that caused the deat				cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	S O I P C	o 11.	10001	act	-ic Ric	ht Hear	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	juence of):	1100	0(-31	10,11	11 11 Car	
	Examiner			Cardic	ae	nic's	hoo	r K		20 hours
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	$\hat{\mathcal{L}}$,	. 1		
	outed ansit	Examine	Cause (Disease or injury that initiated events	Extre	me	Prem	atu	VITY		20 hours
oʻ	an ar	EX	resulting in death) Last	Due to (or as a conseq	uence of):			1		
8760,	The law requires that the death centificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	(d						
9	rtifica ng ph as th	0	IS ESTABLE.							
Вох	eath certific attending p	an/N	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of Month	delivery Day Year
	dea ne att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐Unknown	leath 5	Other (specify)			Monta	Day
P.0	at the de by the a stached	Physician/M	9 Unknown					00- Did		a to the cause of death? •
ŝ	es tha igned be det	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	0	1	Probably 4 Unknown
Vital Records,	w requir been si should	Completed	In Indian	Fold	V -	CANTOIL	1100		Yes 2 No 3	Trobably 4 Gonkholm
ပိ	law r as be	ple	Dissemina	rea Intr	ava	scular	C045	MUTA 24a. Was	psy prior	autopsy findings available to completion of cause of
8		5						perf 1 ☐ Yes	ormed? death 2 No 1 No	/es 2□ No
ita	Physicien: r this certific ral director,	Be (25. Was case referred to medical examiner?					of Death (Check only	one)	
2	hysic this ca	္ရ	1 ☐ Yes 2 No		ER/Outpatier		4 LI NUI		idence 6 Other (S	pecify)
n c	ding Ph h. After th funeral	ë.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	k?		how injury occurred	
<u>s</u>	Je sat	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□N		(0)	Dural Davida Niverbaa
Division of	of or Attandi after death. Director: A d in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti fy)	eet, factory, office		City or To	(Street and Number or own, State)	Rurai Roule Number,
	urs a		con Codillor Al Constitution	alalam Tarta basis of such	audod == d		an date :	d place, and don't be the	cauca(e) and manage	as stated
	To the Hospitel or Attanding within 24 hours after death. To tha Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 → Certifying Phy (Check only one) 2 → Medical Exam	sicien: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	ne, date and pinion, deat	h occurred at the time	, date and place, and	due to the cause(s)
	thin ;	Mec	29b. Signature and title of certifier	2 . 2		29c. Licens			29d. Date signed (Me	
	F 3 F 8		· G CHINTAL	elc, MI)		Dan	100	90	Septemb	er 20, 200 t
•			20 Name and order	ampleted cause of death (tra-	m 22a) /Tu==	DO ()	600	70		1.4.5
			30. Name and address of person who co	Calo 1,00 N	. Wolf	e St. Nel	son	2-133 B	Septemb altimore,	MD 21287
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Şigna	ature 🦽					. ,
	Regist		OCT 0 1 2007	1300 N. 18	Burnah	5 1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 8,9,perFH,C872, 10/1/07 TT Certificate of Death 31336 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 0123AM WILLIE M 09 ETHRIDGE 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MD JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 1915

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M M 2 □ F 240-09-8095 90 12/30/1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5410 CEDONIA USA AVENUE 21206 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 ∰Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRACH COMPANY ANTATION WONKON Coth gante 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HATTIE ELTRIDGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SABONA m) 21206 MU BALTO 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ARRISON FORGST OWING MILLS MD 10-4-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Betts tuneral Home Balto, MD 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE 11 Days Due to (or as a consequence of): PNEUMONIA 11 DAYS ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

death certificate be executed burial-transit and Box 68760 physician as the attending for use P.O. detached þ signed t Records, page 2 should certificate has Division or Vital director,

After this funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t To the Funeral Director: completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

traumatic event, the Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic avant the source and any injury or other t

Physician

/Medical

Examiner

death v

72 hours after

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed

2

Certification:

Medical

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

4940 EASTERN AVENUE BALTIMORE MD 21224 BANKOUA M.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 200 Registrar DENZ)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

27,2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** 9:08 PM eptember 27 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Hos Baltimore 162 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month Day Year)

7-17-1926 7. Age (In yrs. last birthday) Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗖 F 219-22-0206 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show notified at Baltimore MD 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 must be r 21215 Hvenue ural; or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after (and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: Black 3 Widowed 4 □ Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DONDT use retired) (Specify only highest grade completed) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) *Jerk* 1Z Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Anthon 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship Department of Health a Important: If item 27 Is any injury or other trains 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, 3/2007 21. Signature of Funeral Service Licenses 198 of Follipseene Funeral Services Pike, Batto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Ventricular rapture. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due 6 (or as a consequence of) Examiner The law requires that the death certificate be executed bunial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the hours after death uneral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral Completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier uena M.D. September 27. 2007 30. Name and wress if person ho completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Me equeira 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

OCT 0

2007

ORIGINAL

/Medical Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician the as asn for 1 or Attending Physician:

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

is marked otl

Department of Health a Important; If item 27 is any Injury or other tra.

Physician

Pages 1 and 2 should I nent of Health and Men

filed within 72 hours after death with the Maryland

Certification: To

after death filled in by the

within 24 hours a 2

State Registrar

Medical

Ani Balmanuyluan, Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number Res-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Ani Balmanoullian Johns Hopkins Hospital Gow North Weife street Baltmore Maryland 21287 31. Date filed (Month, Day, Year)

OCT 0 1 2007

determined

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

		1 - State of Mary		rtificate of Death	d Mental Hy	Reg. No.2007	31339
Physici	an	1. Decedent's Name (First, Middle, Last) GEORGE D	3	TOHNSON	2. Date of De Month	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D		4c. County of Dea	-
		Bons Secours Hospital		Baltimore			
Funeral Director		212-44-6408 ¹ ♥™ 2□F	n yrs. last birthday) 64 Yrs.	Months Days Hours	Hrs. 8. Date of Birt (Month, Da Sept 8	9. Bir (7. Year) (7. 1943	thplace (State or Foreign ountry) unk
land ow it		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	cation			10d. Inside City Limits
Mary -f sho	tor	MD	Baltimo	re			1∭∑Yes 2 No
n with the 3a or 28s	Funeral Director	10e. Street and Number 1217 W. Fayette Street		10f. Zip Code 21223		10g. Citizen of What Co USA	ountry?
ie, Ividi yidilid ZiZiZiJJOOO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menfall Highen. ffeath and marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1	1	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F I ☐ Yes 2 ☑ No Specify:	? (Specity Yes or No Puerto Rican, etc.)	14. Race - Ame Black, Whi Specify:	te, etc. black
within 72 ene. than "nal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk	(Give	kind of work done during most of OO NOT use retired)		TOD. KING OF DUSINESS	industry
dirical Agic	Be	17. Father's Name (First, Middle, Last)	1	unk 18. Mother's	Name (First, Middle,	Maiden Surname)	unk
aryid should I and Men s marke umatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Number o	or Rural Route Numbe	er, City or Town, State,	Zip Code)
and 2 and 2 salth a salth a er trau		Bons Secours Hospital		W. Baltimore S	treet Bal	timore, MD	21223
3 00		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 AOther (Specify) in state	20b. Place of Dispos cemetery, cren	sition (Name of matory or other place)	Date	20c. Location - City or	Town, State
permit. Pag Department Important: I any injury o		21. Sign ture of coneral Service ticensee Ronal S. Wade, Direct		Name and Address of Facility ate Anatomy Boa Atimore, MD 21	ard 655 W.	Baltimore	Street
Physician /Medical		23a. Part Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	e death. Do not ente		0.0		Approximate Interval Between Onset and Death
Examiner		444	onsequence or):	ENAL FAI	LURE		2 DAYS
uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c. ACU	onsequence of).	STRO- INTE	STINAL	BLEED	2 12475
ufficate be executed g physician and as the burial-transit	edical Exa	Due to (or as a condition of the conditi	onsequence of):	STRO- INTE	AT DI	SEASE	UNTENOWN
The law requires that the death certificate be executed. The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 □ 4 □ Pregnant at tir 9 □ Unknown	pregnancy ☑ Fetal death 3 ☐	∃Ectopicpregnancy] Other (specify)		23d. Date of de Month	elivery Day Year
that the ed by detack		Part II. Other significant conditions contributing to death but it	not resulting in the ur	nderlying cause given in Part I.	23e. Did t	obacco use contribute t	to the cause of death?
w requires to been signer should be	ted by	- Hypertention			11	Yes 2□No 3□F	robably 4 Unknown
The law rate has be page 2 sh	Completed by	- HIO CEREBRO VA	SCULA	A DISEASE	24a. Was autor perfo 1∐ Yes	psy prior to prmed? death?	utopsy findings available completion of cause of s
clan: clan: ertific	Be C	25. Was case referred to medical examiner?			Death (Check only of		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	은	1 Yes 2 1 No Hospital: 1 Inpatient 27. Manner of Death 1 X Natural 5 Pending (Month, Day Y	28b. Time of		28d. Describe	dence 6 Other (Sp.	ecify)
I or Attendate death of the control	Certification:	a Coviside 6 Could not be	- At home, farm, str (Specify)			Street and Number or F wn, State)	Bural Route Number,
e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the basis of examiner state	camination and/or in				
To th within To th comp	Me	29b. Signature and title of certifier	445	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		2501005	/V/3	D 2330	0 1	SEPTEMBE	K21 2007
		30. Name and address of person who completed cause of dear SUDKIR D. PATEL 31. Date filed (Month, Day, Year) 32. Registrar's	th (Item 23a) (Type,	130N 3E	57.13	ALTO: M	D.21223
Sta Registr		OCT 0 1 2007	H Some	6)			

			For State			of Marylar	nd / Depa		t of H		and M			2007	31	3 I. U
			Registrar 1. Decedent's Name	(First, Middle	. Last)		061	incate	OIL	Jeani		2. Date of De.		2001	3. Time of	Death
	Physicia				Kearney							Month Sentemb	Da	10, 200		
	/Medic Examin		4a. Facility Name (If			umber)		4b. City,	Town, or	Location o	of Death	Берсещ		County of Dea		J_MI
					. Assiste	d Livin	g			tt Ci	ty			Howard		
	Funeral		5. Social Security Nu		6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	th y, Year	9. Bir 920 Nor	thplace (State of	or Foreign
	Director		215-22-06 Usual Residence of		- 1	87	113.					July 23	3, L	920 Nor	th Caro	lina
	yiano how		10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C	
:	3a-f	ctor	MD	Howar	d	E	llicot	t CIt	У						1 🗆 Yes	2 No
	illed within 72 hours after death with the Maryland Hygiene, wither than "natural", or Itema 23e or 28e-f show with the Medical Examiner must be notified at	Funeral Director	10e. Street and Num		Daad			10f. Zip		1043			10g. C	itizen of What Co	ountry?	
-	s 23e	eral	3100 N.		nk 12. Was De	codent Ever in II	10 12	Was Docos			ain? (Sp	acify Vac or No		14. Race - Amo	nican Indian	
	in the contract of the contrac	Fun	 Marital Status Never Marrie 		Armed F ed 1 ☐ Yes	Forces?					, Puerto	ecify Yes or No Rican, etc.)	,	Black, Whi		
3	ral', o	þ	3 Widowed	4 Divorced	If Yes, G Year or			1□Yes :	2 X No	Specify:				Specify: W	nite	
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7 :	Hygin other	60	17. Father's Name (First, Middle, I	Last)		110	LSTIE		18. Mothe	er's Name	e (First, Middle,				
<u> </u>	Aental Aental rked tic ev	To B	William	Ellis	Kearney					Lei	na E	lnora M	oss			
	and h	•	19a. Informant's Na	me/Relationsh	nip (Type, Print)									or Town, State,		
≥ ·	l end lealth om 27 ther tr		Rose Mano		sted Liv		310 Place of Dispo			e Roa		llicott		Ly, MD	21043	
2	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innortant: if them 27 is marked other than "natural", or itema 23e or 28a-f ehow eny injury or other treumatic event, the Madical Examinat must be notified at once.		1 Burial 2	Cremation	3 Removal from		cemetery, crer			э)		54.0	200. 1	Location - Oily of	TOWN, State	
	ortani injury		4 ⊠Donation 21. Signature of Fut			6	_22	2. Name an	d Addres	s of Facilit	ty _					
Ö	Ded Tag		21. Signature of Eng	mald S	. Wade,	Director		ate A		_			Ва	ltimore	Street	
					complications that	caused the dear	th. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximat Interval Bet	tween
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	/Medical Examiner		resulting in death)		Due to	ONGES o (or as a consec typer	quence of):		11.		- 7	1.5.				
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ν L	Ine law requires mai me deam sie hes been signed by the etter bege 2 should be detached for i		Part II. Other signifi						ause give	n in Part I.		23e. Did t	tobacco	use contribute t	o the cause of	death?
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	r: In				1 VAS	CULAR	- Dis	GAS	6			1 ☐ Yes			2 □ No	
A I Ca	Atending Physician: r death. sctor; After this certific by the funeral director.	o Be	25. Was case referrence examiner?		Hospital:	Inpatient 2	TER/Outpation	» a□ 00	Othe	\c		h (Check only o		6 SOther (Spe	ASSI	shed
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	death. ctor; Aft y the fun	atlo	1 Natural 2 Accident	5 Pending investig	ation	mini, Day 19ai/	linjury	М		Yes 2□	No					
	fier de direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could r determi	ned 286. Plac	ce of Injury - At h ding, etc. (Speci		eet, factory	y, office			28f. Location (City or To		and Number or Fi te)	ural Route Nun	nber,
	To the Hospital of Atlanding Prysician: The within 24 Hours efter death. To the Funerel Director; After this certificate he completely filled in by the funeral director, page		29a. Certifier	1 Cartifyin	g Physician: To th	he hest of my kn	owledge deat	h occurred	at the tur	e date an	nd place	and due to the	causal	c) and manner a	e stated	
;	P Fur e Fur letely	Medical	(Check only one)	2 Madical I	examiner: On the	basis of examina	ation and/or in	vestigation	, in my op	pinion, dea	th occur	red at the time,	date a	nd place, and du	e to the cause(s)
	vithir To th comp	¥.	29b. Signature and	title of certifier					c. License					ate signed (Mon		
			186	hu		Km		Ţ	>42	-68	00		Se	ptzo	, 200	7
			30. Name and addre			use of death (Ite	m 23a) (Type,	Print)		Nn-		Pire	40	M 9 2	1042	190
	Sta	te.	30. Name and address	SHEIK	H ms	use of death (Itel 405) Registrar's Sign	m 23a) (Type, BAL) ature	Print)	re	NATO	MMO	L Pike,	4C	ptzo mg 2 . Ell	1042 10077	17

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:10 P M September 24, 2007 Joyce M. Lechliter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 ₩ F Director 21, 1928 Minnesota 468-28-9432 79 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dkal Examiner must be notified at 1 ☐ Yes 21 No Director Maryland | Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1440 Washington Ave. 21144 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administator Government 12 should be filed w h and Mental Hygier 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Egnar Gunnarson Elvira Bjornberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any Injury or other trau 3202 Ivy Way; Harwood, MD 20776 <u>Jay Lechliter / son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 28, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Lechliter Monnet Cem. Fort Ashby, WV 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. S.E.; Glen Burnie, 21. Signature of Funer Service License CN MD 21061 Glen Burnie, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examiner be executed burial-transi and Box 68760_{γ} Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ned by the a detached 1 P.O. 9 Unknow s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has perform 2 100 certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, Wospice worse Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No death. ours after death.

reral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 9 To the Hospital within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature 29d. Date signed (Month, Day, Year) ttle of certifier SETTATE POSID ANN 30 Name and address of pe 8815 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007

Registrar

	1	For State Registrar	State of Maryland / Depa	ertment of Health and tificate of Death	Mental Hygier Reg. I	
Physiçia /Medic	ın	1. Decedent's Name (First, Middle, Last) David Hilliard Moc	ney		2 Date of Death Sept. 26	3. Time of Death 7:05 P
Examine		4a. Facility Name (<i>If not institution, gi</i> ve s 8207 Joselle Court		4b. City, Town, or Location of Dea Fort Washington		4c. County of Death Prince Georges
uneral rector		379-00-4373	7. Age (In yrs. last birthday) M 2□F 47 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Fore DC ountry)
f show		Usual Residence of Decedent 10a. State 10b. County MD Prince Ge	orges Fort Wash			10d. Inside City Lin
3a or 28e-	i Director	10e. Street and Number 8207 Joselle Court		10f. Zip Code 20744		Citizen of What Country?
28	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (: f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 Ho Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
s marked other then "nature umafic event, the Mudical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Deced (Give 16b. 16c. Deced (Give 16b. 16c. Deced 16c. Deced (Give 16b. 16c. Deced (Give 16b. Deced	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b	. Kind of Business/Industry Private
event,	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid Aiken	den Sumame)
umarke umarfc	ဥ	Narvail Mooney 19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or F	Rural Route Number, Ci	
Importent: If item 27 is marked eny injury or other treumatic es gocs.		Rochelle Mooney - 20a. Method of Disposition 1X Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)	20b. Place of Dispo	Joselle Court, sition (Name of natory or other place) ion Cem. 10/3	Date 20c	Location - City or Town, State inton, MD
Importer eny inju		21. Signatural of Funeral Service Licens	Johnson 65	2. Name and Address of Facility Be	all and John	nson Funeral Home
physician and edical edical miner the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, leading to mmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cations that caused the death. Do not entill cluse in each line. CS	failure		Interval Between Onset and Deat
ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
5.8		Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of deat
ıcate has been si r. page 2 should	Completed				24a. Was an autopsy performed	
r: After this certi e funeral directo	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Cther: 4 Nursing	Home 5 Residence 28d. Describe how	e 6
ector by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number State)
ed in		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	nicien: To the best of my *newledge dear ner: On the basis of examination and/or in and manner stated.	becomed at the time, date and da exestigation, in my opinion, death oc	tie, and due to the name curred at the time, date	is(s) and manner as stated a and place, and due to the cause(s)
De Funeral Dir	dica	one)				
within 25 mous area to conflict he Ton the Funeral Director. After this certificate he completely filled in by the funeral director, page	Medical	29b. Signature and title of contain	ompleted cause of death (Item 23a) (Type)	29c. License number D0038 29	2	Date signed (Month, Day, Year) Oct 1, 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State of Maryland / Department of Health and N 1 - Registrar Certificate of Death	, ,	ene PNO DO TORILLE	a
		740	1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death	
	Physici /Medic		Mhaduri Rajnikant Trambaklal Mehta	Month Septembe	r 26, 2007 11:55A M	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	_
		Ш	Prince George's Hospital Cheverly		Prince Ceorge's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)	,
ىپە	Director		363-17-6490 55 Yrs. Usual Residence of Decedent	May 30,	1952 Kenya	
	land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	
	Mary fied a	호	Maryland Prince George's Laurel		1 XYes 2 No	
	r 28a	Director	10e. Street and Number 10f. Zip Code	100	J. Citizen of What Country?	
	h witl 23a o st be		106 Sharon Court, #304 20707		Britain	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,	
9	after or ite		1 Never Married 2 Married 1 Yes 2 No	nican, etc.)	Black, White, etc.	
8	72 hours after death with the Marylan natural", or items 23a or 28a-f show dical Examiner must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:		Specify: Asian-Indian	
21215-0036	~ * O	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	king [6b. Kind of Business/Industry	
12	withir ene. than he M	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+) 2 Designer		Fashion	
d 2	Hyg Sthe			ne (First, Middle, Ma		
Maryland	و ق ق و	To Be	Prabhauat U. Sharma Vallat	bram R.	Sharma	
яŊ	2 shoul and M is marl aumati	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Run			-
	rt.		Rajnikant T. Mehta/husband 106 Sharon Court, #304	4 Laurel	. Maryland 20707	
J.	es 1 a of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Town, State	_
Ē			Tobular 2 Morellation 3 Chemoval form State	0/2007	Odenton, Maryland	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Sign to e of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral I	Home & Cr	ematory, P.A.	
			1411 Annapolis Road	<u>l Odento</u> i	n, Maryland 21113	
			23a. Part to nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each time. Immediate Cause (Final	or respiratory arres	t, Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a or ness) ence of):			
	Examiner		1. Rome Condam	وسرهاميده	. DE	
		Jer	Sequentially list conditions, it say, leading to himsediate cause. Enter Underlying Cause (Disease or injury that initiated events c	70700		_
	ecutec nd transi	Examiner	Cause (Disease or injury that initiated events c. Annum Unler	n De	sease	
90,	e execian a		resulting in death) Last Due to (or as a consequence of):	J		
68760,	rificate be executed g physician and as the burial-transit	edical	d. Hallely			_
	certifi ding se as	_	IF FEMALE: 23c. If yes, outcome pf pregnancy			_
Вох	atten for u	cian	in the past 12 months?		23d. Date of delivery Month Day Year	
P.O.	The law requires that the death centen has been signed by the attendinge 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			
	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?	
Vital Records,	w require been sig should b	q pe	Keraf Falling	1 ☐ Yes	2 No 3 Probably 4 Inknown	
ည္က	aw re Is bee	Completed	H isser lenger	24a. Was an	24b. Were autopsy findings available	
č	The lav	ШО		autopsy performe 1 Yes 24	prior to completion of cause of death?	
ita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?	th Check onl one	1140 1 Li 163 2 2 2 140	
or V	Physician: this certific ral director,	To E		ome 5 Residence	ce 6 ☐Other (Specify)	
u o	Ing P		27. Namer of Death 28a. Date of Injury 1 Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury 48c. Injury at Work? 28c. Injury at Work?	28d. Describe how	injury occurred	_
sio	Attending r death. ector: After by the fune	cati	21 ccident investigation M 1 Yes 2 No			
Division	or At after d Direc in by	Certification:	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cau	se(s) and manner as stated	
	n 24 h	Medical	(Check only /2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one)	red at the time, date	e and place, and due to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number	29d	I. Date signed (Month, Day, Year)	_
)			1/ plane 030318	5 6	9/26/67	
0	V OT		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAMES CATEVENAS 3001 HOSPIFAL DR CH		1 25-	
0	'		ISAMES CATEVENAS 3001 HOSPITAL DR CH	everly 1	mo 20785	\Box
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 1 2007 32. Redistrar's Signature	,		

DHMH 17 Rev 1/2001

			_ FOr	State of Mar	ryland / Depa			Mental Hy	giene	007	2121.5
		_	1 - State Registrar		Cer	tificate of L	Death		Reg. No.2	001	3 3 4 5
	Physicia	an .	1. Decedent's Name (First, Middle, Last)	/	M. DP.			2. Date of De Month	Day	Year	3. Time of Death
water.	/Medic		4a. Facility Name (If not institution, give si	treet and number)	Matte	4b. Cify, Town, or	Location of Death	09	22 40 Col	o 7	5:05.4M
	Examin	ier	0	ce at t	thelaka	5. L.	hu a .				ester
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	place (State or Foreign
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7	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion				1	I 0d. Inside Cify Limits
2	show	5									1 ☐ Yes 2 ⊋ No
4	28a-f	Director	MD Worcest 10e. Street and Number	er	Berl	10f. Zip Code		1	10a Citizen	of What Cour	Α.
4674	Sa or	اقا	41 Chatham Court			7011 21 0000	21811			USA	
400	ms 2%	Funeral		2. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No)- 14.	Race - Americ	
0	or ite	T.	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		1 Yes, specity Cuba 1 □ Yes 21X No	n, mexican, Puen Specify:	to Hican, etc.)		Black, White,	
2	ural",	d by	3 ☐ Widowed 4 💢 Divorced	Year or Dates:						ecify: Whi	
ה ה ה	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	tent's Usual Occupa kind of work done d DO NOT use retired,	ation Luring most of wor	rking	16b. Kind o	of Business/In	dustry
7 i	than than	E I	Elementary/Secondary (0-12)	College (1-4or 5+))	1 estate			nro	narty	
מ קרוש	Hygir Hygir Ither Int, th		17. Father's Name (First, Middle, Last)		lea		18. Mother's Nan	ne (First, Middle		perty name)	
2 2	ental ental ked c	To Be	Robert Vanderbeck	Shinn			Grace	Newman			
מוסלים	z should be med and Mental Hygid Is marked other aumatic event, the	-	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	ng Address (Street a	and Number or Ru	ural Route Numb	er, City or To	wn, State, Zip	Code)
, K	s I and 2 should be filed within 72 hours after bearth with the maryland them 27 Is marked other than "natural", or items 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Scott Maffre/son		8828	Lew-Wall	ace Road	l Freder	ick, M	D 217	04
ָ ס	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date	20c. Locati	on - City or To	own, State
	ment tant: I		4 ☑ Donation 5 ☐ Other (Specify)	~							
Dailling	permit. Pages I and Z Department of Health a Important: If item 27 is any Injury or other tra		21. Signalur, u. Funeral Sevice License	åde Dire	ctor S	Name and Address tate Anat altimore,	s of Facility Comy Boar	sd,655 W	. Balt	imore	Street
	20280	\vdash	23a. Party. Enter the disease, or complic	1 Jack	be death. Do not ont	altimore,	PID Z12	201	react		Approximate
			shock or heart failure. List only on Immediate Cause (Final	e cause on each line	٠.					3	Interval Between Onset and Death
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cords,	en sig							1 🗆	Yes 2	ho 3 □ Prol	bably 4 □Unknown
ב ב	as be 2 shd	plet						24a. Was		4b. Were auto	opsy findings available ompletion of cause of
	ate h	Completed						perf 1⊟ Yes	ormed? €□No	death? 1 ∐Yes	≥ EPNo
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2 5	or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not be	28e. Place of injur	y - At home, farm, str (Specify)		_			umber or Run	al Route Number,
	an or y a after al Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)			City or To	wn, State)		
Local	to the postulate Abenium Proystolars. The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifying Phys								
To the	within To the compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date s	igned (Month,	Day, Year)
				6		00	05841	0	9	1220	67
			30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,						
	100		GHULAM WARIS,	COASTA	+ Hospi	cr Po	130× 1	733,	SALIS	Busy	e mo 21802
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 1 2007	32. Registrar	s Signature	and the same					

07-07409 Robert Puckett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31346

obe	en rucken		- For State	ate of ivial yland?	Certificate	of Death		Reg	. No.	
	Physicia		egistrar 1. Decedent's Name (First, Middl	e,Last)				Date of Death Month	Day Year	3. Time of Death 1604 hrs
led	ical Examir		Robert W. Pu	ckett				September	22, 2007	
1			4a. Facility Name (if not institutio	n, give street and number)			wn, or Location of	Death , :	4c. County of De	
			Baltimore Washington			Glen B	urnie "		Anne Arund	
	Europal		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthda	y) If Under			(MM/DD/YYYY) 9.	eign
	Funeral Director	- 1	,	1 X M 2 F	44	Yrs. Months	Days Hours	Min.	5, 1963	Country)Georgia
	Director	L	215 <u>-92-5555</u>	1 X M Z F	44	113.		ADILL	J, 17031.	0001914
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	w any					•				1 Yes 2 X No
-	and sho	5	Maryland Anne	Arundel	Glen B	urnie 10f.Zip (2040	110	g. Citizen of What C	ountry?
7	with the Maryland ns 23a or 28a-f show be notified at once.	OυI	10e. Street and Number			Tor. Zip C	Code		9. 0	
2	the Na or	히	906 Princeton	Terrace		210	60		United St	
	with IS 23	ē	11. Marital Status	12. Was Decedent		3. Was Deceden	t of Hispanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black, '
	iten iten	uneral	1 Never Married 2 X M	Armed Forces?	X No	ii tes, specify	- Caban, Monaco,			
	ter d	ш.	3 Widowed 4 Div	vorced If Yes, Give Year			No specify:			hite
	11215-0036 the filed within 72 hours after death fental Hygiene. narked other than "natural", or iten event, the Medical Examiner must	ē	15. Decedent's Education (Spe	ecify only highest grade com	pleted) 16a. Dec	cedent's Usual C	Occupation (Give king life. DO N OT u	ind of work done	16b. Kind of Busine	ss/Industry
	2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+) dur	ing most of work	ang me. Do No 1	200 10111127		
	36 hin 7 e. than	힐	12		Bu	siness (Owner _		Masonry	
	5-00 ed with tygien other ihe M	팃	17. Father's Name (First, Middle	, Last)			18.Mother's	s Name (First, Middle, M	laiden Surname)	
	files	Be	Cevert Pucket	-			Walt	raud Rosen	berger	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than	T0 E	19a. Informant's Name/Relation	ship (Type, Print)	19b. I	Mailing Address	(Street and Num	ber or Rural Route Num	ber, City or Town, S	tate, Zip Code)
	O sho sho I si z is z is		Toni Puckett		90	6 Prince	eton Ter <u>r</u>	cace; Glen	Burnie, M	D 21060
	e, MD 1 and 2 sh Health an i item 27 i		20a. Method of Disposition	HILL	20b. Place of I	Disposition (Nam	ne of cemetery,	Date	20c. Location - Cit	y or Town, State
	more Pages 1 sent of H ant: If it		1 X Burial 2 Crematic	n 3 Removal from St	ale	y or other place)		Sept. 27, 2007		nie, Maryland
	Page ment tant:		4 Donation 5 Other	Specify:	Glen H	OO Nisses and	Address of Eacility	,		
	Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service	e Licensee		l Kirkla	v-Ruddic	k Funeral I	Home, P.A.	MD 21061
	m go = :		23a. Part I. Enter the disease,		the death Denet	421 CT	of dving, such as c	S.E. Glen	est, shock, or heart	Approximate Interval
	Physician		failure. List only one caus	e on each line.						Between Onset and Death
1	Medical aminer		Immediate Cause (Final diseas	e a. Hypertens	ive cardiov	ascular d	isease			
Mh.	.almilei	1	or condition resulting in death)	Due to (or as a cons	sequence of):					
			Sequentially list conditions,	b			200	-		
		ner	if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a cons	sequence of):	•				3,4
		Examiner	(Disease or injury that initiated	C	sequence of):					
	ed	×	events resulting in death) Las	d.	,					
	760, Totale be executed by sician and the burial - transit	edical	X UNPENDED		7 1/5 03	10/2/0	7 mm			
	60, ate be e shysician	ğ	1 - 1 - 1 - 1 - 1		7, perME, g87	2 , 10/3/0	// <u>11</u>		23d. Date of de	livery
	68760, certificate be nding physici use as the buri	ĮŠ	IF FEMALE: 23b. Was decedent pregnant in		office of pregnancy	Fetal death	3 Ectopi	ic pregnancy	Month	Day Year
	68 certil	iai	past 12 months?	4 Pregnant a	at time of death 5	Other (Spe				4
	Box 687 e death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 L							(d - 4)-2
	ords, P.O. Box 687 **requires that the death certification is seen signed by the attending particular be detached for use as the	占		ditions contributing to dea	ath but not resulting	in the underlying	g cause given in P			ite to the cause of death?
	P.O. es that the igned by be detac	_ ≥						1Ye	s 2 V No 3	Probably 4 Unknown
	aprire quire ald bi	te						24a. Was		ere autopsy findings available or to completion of cause of
	aw re								ormed? de	ath?
	The la								2 No 1	Yes 2 No
	Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter companies, the funeral director: After this certificate, has been signed by the atterior has been signed by the attendance of the funeral director. Date 2 should be detached for up	Be C					Other:	(Check only one)	1	Other
	Vita hysteia this ce	8		Hospital: 1 Inpa	tient 2 🗸 ER/Ou	itpatient 3	DOA Other	Nursing Home 5		Other:
	ling Phy After tl	1 6	27 Manner of Death	28a. Date of Ir (Month, Day		ime of Injury	28c. Injury at Wo	rk? 28d. Describe	how injury occurred	1
	ndfing it. Al	Certification	1 X Natural 5 P	ending	y, 1 dai y		1Yes 2			
	VISIOF or Attend after death Director:	7	2 Accident In	vestigation 28e. Place of	Injury - At home, fa	rm, street, factor	ry, office building,			or Rural Route Number, City
	ivisi I or Att after de	1	3 Suicide 6 C	ould not be (Specify)				or Town,	State)	
	Div Nospital of 24 hours at Funeral I				my knowladge des	ath occurred at th	ne time, date and p	place, and due to the ca	use(s) and manner a	as stated.
	To the Hospital within 24 hours	Medical	(Check only 1 Certifying one) 2 Medical E	g Physician: To the best of examiner:On the basis of ex	xamination and/or in	nvestigation, in n	ny opinion, death o	occurred at the time, da	e and place, and du	e to the cause(s)
	To the within 2	1	2 11112 25 22	and mariner state	ed		9c. License numbe		29d. Date signe	d (Month, Day, Year)
		2	29b. Signature and title of cer	unet .			O.C.M.E.		September	23, 2007
1	1h 0	+	his	an. u	J (/		U.U.IVI.L.		- 54	
	THE WA	1	30. Name and address of per					1004		
5	0 10		Ling Li, MD Assi	stant Medical Examir	ner 111 Peni	n Street, Bal	timore, MD 21	1201		
		Stat	e 31. Date filed (Month, Day Ye	ar) 1 2007 32. Regis	trar's Signature	Cornelle	9			
	Reg		1 1 1		news 15	19				
		1/200		OCME	OF	RIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:18 PM 09 Karen Perry 23 07 /Medical 4c. County of Death 4a. Facility Name (If not institution give street and number) 4b. City. Town, or Location of Death Examiner Baltimore If Under 24 Hrs. 5. Social Security Number Maryland Medical Center If Under 1 Year | Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 😿 F Months Min. Pennsylvania September 5, 1972 Director 208-58-5267 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show items 23a or 28a-f shov ner must be notified at 1 Yes 2 No Pennsylvania Franklin Director Chambersbura 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 1 North Franklin 1720 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: White Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home maker f Health and Mental Hygier item 27 Is marked other the other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue Perry Richard Vickle Α. Binner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. 137 North Franklin Vickie Sue Pensinger Chambersburg, PA 17201 / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State September 29, 2007 Ardent Cremations Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremetions 21. Signature of Funeral Service Licensee Laura C. Hardesty Mo1197 7522 Connelley Drive Suite N Hanover MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hemorrhagic cerebrovascular accident **Physician** disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner nducarditis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown <u>Nenatitis</u> Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1x CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral C

> State Registrar

29b. Signature and title of certifier

Tiffany

31. Date filed (Month, Day, Year)

22 South Studdaro 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ÖRIGINAL

Greene

29c. License number

AU4176435821678

St, Baltimore MD 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1 per PHYS. G872 10/1/07 WS
State of Maryland / Department of Health and Mental Hygiene 31348 Certificate of Death Reg. No UU 1. Decedent's Name (First, Middle, Last) Author 2. Date of Death 3. Time of Death \mathbf{L}_{ullet} Peete **Physician** Month Dav 492001 Arthor estemb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 9104 Limon Ct. Ft. Washington Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Days Hours Director 409-72-3542 63 Dyersburg, Tn. Nov.22,1944 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1-Yes 2□No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9104 Limon Court Funeral 20744 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Pages 1 and 2 should Freddie Peete other traumatic ည Allene White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Maryland Peete/Wife 9104 Limon Court, Ft. Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2007 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Sept.19, Cheltenham, Maryland 21. Signatur of Funeral Service censee 22. Name and Address of Facility Pope Funeral Homes, P.A. 01 D1 D85 5538 Marlboro Pike, Forestville, Maryland 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** 4 theroscleratic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed sician and burial-transi Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the l asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached t 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Physician: 25. Was case referred to medical examiner 2 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Mannor of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 To the Hospital of within 24 hours af To the Funeral D Hospital filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 3001 Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 1 2007 Registrar

DHMH 17 Rev 1/2001

07-07528		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
EITH RAY		State Maryland / Department of Health and Ment Sygiene Certificate of Death State Maryland / Department of Health and Ment Sygiene Certificate of Death	
Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 25, 2007 3. Time of Death 1340 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 600 Wyman Park Drive Baltimore City 4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Director		219-71-4566 1√M 2 F 24 Yrs. Months Days Hours Min. 11-11-1982 Foreign Country) md,	
nd show any	٦	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No	
	Director		10e. Street and Number 328 W: Lorraine Ave 21211 10g. Citizen of What Country? USA
th with tems 23	Funeral	11. Martiel Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Married 2 Married 3	
after des		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black	
hours a	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
15-0036 filed within 72 hours after I Hygiene. do other than "natural", c. t, the Medical Examiner.	Completed	9th NA never worked N/A	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sheila A, Davis	
ID 21; t should b and Men 17 is mar	입	19a. Informant's Name/Relationship (Tr. e, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, MD 1 and 2 shu Health and item 27 is	ł	Felisha Kay - Sister 4260 Shellon are Balto, md, 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donatton 5 Other Specify: Multiple Crematory 9-29-07 Cath Sville mD.	
Baltimo permit. Page: Department o Important: injury or oth		21. Supr ture of Fineral Service Licensee 22. Name and Address Lacility 270 Fred HILTON Pass Gary P. march F. H. Barto, and 21229	
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and	
/Medical Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound to the head Due to (or as a consequence of):	
No.		Sequentially list conditions, b	
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
executed an and al - transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.	
O, be exected sician a sician a	edical	UNPENDED AMENDED	
6876 ertificate fing phy	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	
Box death or he attended for us	ysici	1 Yes 2 No 9 Unknown Unknown 1 Unknown 4 Pregnant at time of 5 Other (Specify)	
Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be executed as fater death. The law requires that the death certificate be executed and Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transiti	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown	
rds, requires been sig	Completed	24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of	
Reco The law cate has	шo	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
ital Rician:	8	25. Was case referred to medical examiner? 1 Ves 2 No Other: Scene	
a of V ing Phy: After thi	일	27. Manner of Death 28a. Date of Injury (Month Day Year) (Month Day Year)	
Sion Attendi r death. ector: by the f	Certification:	2 Accident Investigation 229 Place of Jains, At home form street fectors office building etc. 291 Legation /Street and Number of Pural Pouts Number City	
Divi	ertifi	Suicide 4 W Homicide Solution of the determined (Specify) Woods Solution of the determined (Specify) Woods Solution of the determined (Specify) Woods	
	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F. 2 F. 8	ĕ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		30 Name and address of person who completed cause of death (New 23a)	
1		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr		31. Date filed (Month, Day, Year) OCT 0 1 2007 32. Registrar's Signature	
	_	ACME	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 26, **Physician** Timothy James Seabolt 2007 7 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 3513 Horton Ave. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 4, 1944 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Pennsylvania 63 218-44-5542 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Baltimore City Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. 3513 Horton Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Manager th and Mental Hygien 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Pauline McDermott Chester Seabolt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 278 Morris Rd. Fawn Grove, Pa. Health Chester Seabolt, brother 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: If itel
any injury or ott 1 ☐ Burial 2 Peremation 3 ☐ Removal from State 4 ☐Donation 5 □ Other (Specify) 9/29/07 Bayview Crematory Baltimore, Md. of Funera Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. Baltimore, Md. 21225 4001 Ritchie Hgwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE NOW-SMALL CELL LUNG CANCER **Physician** 4R5 /Medical Kronic obstructive Pulmonary Disease Examiner 415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to Adrenal gland and burial-transi certificate be exec physician s the burial Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. a∏tJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performe page 1 Tyes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending investigation 1 TYes 2 TNo the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🔂 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier Tuse Ave, D-1, Frederick, Md 21701 10/1

DHMH 17 Rev 1/2001

State

Registrar

🥦. Registrar's Signature

OCT 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. 30 Pay Physician 9:10 A. M Elfrieda C. . Snow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 414 Arbor Drive 8. Date of Birth Feb. 14, Year 930 MACO Trand 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 77 218-22-9048 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Maryland Glen Burnie Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 414 Arbor Drive United States ral", or items 23a Examiner must b by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify White Specify. 3 ☐ Widowed 🏕 Divorced r than "natural", the Medical Exa Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Sales Representative Cosmetics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Pages 1 and 2 should be nent of Health and Mental Effie Milton Collier Lee or other traumatic ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau Stevensville, MD 21666 906 Kimberly Way Kathy Foster / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 3. Parial 2 Cremation 3 Removal from State 2007 5 ☐ Other (Specify) 4 □ D Glen Haven Mem. Pk. Glen Burnie, MD 22. Name and Address of Facility al Serv 21. Signatu e of icensee Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due a consequence of) Examiner n10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical as the attending | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 KM o ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been siç , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed 1□ Yes 2□X certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 211 No 1 Yes 1 [] Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 1 → Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Yes 2 Accident the 3 ☐ Suicide 6 Could not be . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760,

or Attending Patter death. within 24 hours a To the Funeral I Hospital the

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Medical

29a. Certifier

(Check only one)

29b. Signature and tij

30. Name and address of pers

31. Date filed (Month, Day,

State

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

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Year

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1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and

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who completed cause of death (Item 23a) (Type, Print)

Year

Sw Clem Barne MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5, 2007 eptember 28 Joan M. Swan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner en 5 (かんん) 2 Baltimore Washington Medical Center If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 □ M 2 ▼ F Scotland 84 12-27-1922 031-12-5180 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notiffed at 1 ☑ Yes 2 ☐ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 death v Funeral 705 Berry Road U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: <u></u> White 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Murdock MacLeod Bessie MacIntosh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mrs. Linda Hicks / Daughter 389 Valiant Circle Glen Burnie, MD 21061 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important; If any injury or once, Chesapeake Cremation | 09-30-2007 Stevensville, MD 22. Name and Address of Facility $Singleton\ Funeral\ \&\ Cremation\ Srv$ 21. Signature of Funeral Service Licensee. 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🗃 🖓 tural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death.

Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft.

To the Funeral DI

completely filled in retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

15017

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Approximate Interval Between Onset and 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. September 23, 2007 Williame 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DOME **ÖRIGINAL** DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09-25-2007 900 P M Ruth M. Sheets 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Timonium Baltimore Stella Maris Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Date of Birth (Month, Day. Days Hours 1 □ M 2 💢 F 215-32-8478 72 09-17-1935 NE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2X No Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 U.S.A. 2152 Thomas Run Rd 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Factory Presser 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl Simons Virgie Vipperman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosie Blankenship (Daughter) 2723 Sharon Rd Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-28-2007 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Gar. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes in each line. Immediate Cause (Final week disease or condition resulting in death) Due to (as a consequence of) ment Sequentially list conditions, Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

Department of Health a Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

for use as the burial-tran requires that the death certificate be been signed by the sahould be detached cate has I page 2 s

P.O. 1

Records,

Division or Vital

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SEPTEMBER

this certificate Hospital or Attending Physician: director, After this funeral of To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled it by the fu

Part II. Other signific	cant conditions cor	23e. Did tobacco us	23e. Did tobacco use contribute to the cause of death?						
		1 □ Yes 2.2	No 3 Probably 4 Unknown						
							24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No	
25. Was case referre	ed to medical			Check onl one					
examiner? 1 ☐ Yes 24€ 1	40 F	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	B□ DOA	ome 5 Residence 6 Other (Specify)				
27. Manner of Death Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	i. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28e. Place of injury - At he building, etc. (Specifical Control of the control of	ome, farm, street,	factory, c	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

29b. Signature and title of certifier m esting

29a. Certifier

(Check only one

and manner stated.

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)



Emilia de la Caridad Silva/Wife 7614 Trail Run Road, Falls Church, Virginia 22042

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan

Euda Giralt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

22. Name and Address of Facility Pope Funeral Homes, P.A.

5538 Marlboro Pike, Forestville, Maryland 20747

9/28/2007

20c. Location - City or Town, State

Alexandria, Va.

within 72 hours after death with the Maryland a or Pages 1 and 2 should be filed within 72 hours after death winnent of Heatth and Mentai Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a.
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Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f sh notified

Director

Funeral

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Completed

Be

11. Marital Status

Ramon Silva

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Interval Between Onset and Death		
	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Entite Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
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<u>></u> .∞ ♥	To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe	cify)		
o the Hospital or Attending Physician: ithin 24 hours after death. o the Funeral Director; After this certific ompletely filled in by the funeral director,	ation:	27. Manner of Death 1 X Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Month, Day Year) 28b. Time of Injury 4 Work? 1 Yes 2 No			
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To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date and place are death occurred at the time, date are death occurred at the time, date are death occurred at the time, date and place are death occurred at the time, date are death occurred at the time, date are death occurred at the time, date are death	stated. to the cause(s)
Tot withi Com	×	29b. Signature and title of certifier Alfundif D24208 29c. License number D24208 29d. Date signed (Montage D24208) 29c. License number D24208	n, Day, Year)		
0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIC Ward Gardfeld To AMLHASHV ANSARI MI) C(6) + 4m arch 2033	11		
Sta Registr		31. Date filed (Month, Day, Year) 32 degistrar's Signature			
HMH 17 Rev 1/20	001	ORIGINAL			

			1 - For State Registrar	State of Marylan		artment of rtificate of			jiene 2007	31357
	Physici		1. Decedent's Name (First, Middle, Last) Roland Urquhart					2. Date of Dea Month	Day Year	3. Time of Death 3.154 M
	/Medio Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Dea	th	4c. County of Dea	
	Funeral Director		5. Social Security Number 180-30-0319 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days			Year) 9. Bii 1933 Man	rthplace (State or Foreign ountry) cyland
	show ed at	J.C	10a. State 10b. County MD Harford		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 € No
	r 28a-f	irecto	10e. Street and Number	A	Derdee	10f. Zip Code			log. Citizen of What C	
	th with	a D	1011 Warwick Driv	e #1A			21001		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show airy injury or other traumatic event, ite Medical Examinar cutal 2a modified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U. Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ሺ No	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
21215-0036	ithin 72 ho 16. 14n "naturi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retir	e during most of we	orking	16b. Kind of Business	s/Industry
72	lied w tygier ther th		12 17. Father's Name (First, Middle, Last)	0	ma	nager	18 Mother's No	ame (First, Middle,	automoti	ive unk
Maryland	should be fi and Mentai H s marked ot umatic ever	To Be	Benjamin Urquhart	o Orient	10h Maili	n= Addrna /Stra			r, City or Town, State,	
Mai	od 2 st lth and 27 is r traur		19a. Informant's Name/Relationship (Type Pat Richardson/fri			•		lA Aberde		001
Baltimore,	Pages 1 ar nent of Hea snt: if item: ury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 3 ◯ Other (Specify)	I 6	lace of Dispo emetery, crea	osition (Name of matory or other pl	ace)	/ Date	20c. Location - City o	r Town, State
Balti	permit. Departrimporta		21. Signatur of Funeral Service License S. W	ad, director	/ 1 .	2. Name and Add tate Ana altimore			Baltimore	Street
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (final disease or condition resulting in death)	ations that caused the death cause on each line. Due to (or as a consequence)	Sta	ter the mode of dy	ring, such as cardio	ac or respiratory ari	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
P.O. Box 68	the death certifi y the attending ched for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3	⊒Ectopic pregn <i>a</i> n ⊒ Other <i>(specify)</i>	icy		23d. Date of do Month	elivery Day Year
	8 5 6	2	Part II. Dther significant conditions conf	nbuting to death but not res	ulting in the u	nderlying cause g	given in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Il Records,	The law ete has b page 2 st	Completed						24a. Was a autop perfor	an 24b. Were a prior to death?	autopsy findings available completion of cause of
Viita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:		- 10	thor	eath (Check only or		
ō	Phys er this eral di	To	27. Mann of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. In	4 Zamursing		lence 6 Other (Sp ow injury occurred	ecify)
Division of Vital	To the Hospital or Attending Physician: within 24 hours elter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	1 atural 5 Pending Investigation 3 Suicide 4 Homicide Pending Investigation 6 Could not be determined	itreet and Number or F m, State)	Rural Route Number,					
	ne Hospita n 24 hours ne Funeral	edicai C	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examin	ce, and due to the courred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)				
29b. Signature and title of certifier									29d. Date signed (Mor	nth, Dey, Year)
7			30. Name and address of person who con	npleted cause of death (Item	1 23 <i>a</i>) (Type,	Print)	1387	etica et	Abero	leen, Manila
	Sta Begist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	NED O	-UW-	11001	7	100/

			1- State of Maryland Den 1- State Registrar Ce	atment of Health and M rtificate of Death	Mental Hygier	ne No.2007	31358				
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death				
	Physici /Medic		Lawrence E. Wimbrow		September	Day Year 18, 2007	6:25 AM M				
Ž	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			10804 Worcester Highway	Berlin		Worcester	c				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar 24, 1	9. Birthi	place (State or Foreign ntry)				
	Director		1//-14-2030 04		Mar 24, 1	1923 Illi	nois				
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
	Mary	ŏ	MD Worcester Berli	n			1 ☐ Yes 2 ☑ No				
	the notified	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?				
	3a ou		10804 Worcester Highway	21811		USA					
	death	Funeral		Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amen					
9	after or its	Ē	Armed Forces? 1 □ Never Married 2 Married Married Never	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, Specify: whi					
ဗ္ဗ	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or iteme 23e or 28e-f ehow event, the Macdical Exartinar must be notified at	d by	3 Widowed 4 Divorced Year or Dates: 143-46	To res zignito opeciny.		Specify: WII					
2	72 h	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation a kind of work done during most of work	ung 16b	. Kind of Business/Ir	dustry				
7	within the	ш	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		rolicion					
2	illed y		12 5+ min:	ister	e (First, Middle, Maid	religion					
and	d be sold of the control of the cont) Be	Lawrence E. Wimbrow		ane Brown	333					
<u> </u>	should and Men marke umatic	2		ing Address (Street and Number or Ru		ty or Town, State, Zij	Code)				
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mental Hyglene. If item 27 is marked other than "natural," or iteme 23a or 28e-1 show or other treumatic event, the Marical Examinar must be notified at		19a Mornari Nama-Relationship (Type, Print) 19b. Mail Cindy Wimbrow/ spouse 108	304 Worcester High	way Berlin	n, MD 2181	.1				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Heelth a Important: If item 27 li eny injury or other tre	1	20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20c	. Location - City or T	own, State				
Ē	Page ent o nt: If ry or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)								
ati	mit.		21. Signature of Funeral Project Licensee Director S	I 655 W. B:	altimore Street						
Ö	Depa Impo eny ir	3	areimore i	ic berees							
		Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, such as cardiac or respiratory arrest, into the mode of dying, are the mode of									
	Physician		Immediate Cause (Final			Onset and Death					
	/Medical		resulting in death) a. Due to (or as a consequence of):	acced at							
	Examiner		Sequentially list conditions b.								
	D #	Examiner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying								
	and and I-trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	icate be executed physicien and s the burial-transit	a E	330 10 (0) 43 4 30/130430100 31/).			İ					
687	icate phys s the	dical	d								
×	eath certifi attending I for use as	W/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	Date of delivery				
Вох	atter d for t	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year				
<u>о</u>	that the de ed by the detached	Physician/Me	9 Unknown 9 Unknown								
	The law requires that the death certift sie has been signed by the attending ipage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?				
ğ	w require been sig should b	ed II	Atrial thoullation		1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown				
00	aw requisite the second	piet	Sarve Kronda		24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of				
m m	The lav	Completed			performed	1? death?					
ita	ysician: Th	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)						
<u>></u>	d is	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Residence	e 6 □Other (Speci	fy)				
Division of Vital Records,	ing P	on:	27. Manner of Death 1	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	injury occurred					
<u>s</u>	Attending ir death, ector: Atte by the fune	cat	204		-/ D M						
\leq	after after Direction by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospitei 24 hours a Funerai I		29a. Certifier 110 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cause	e(s) and manner as	stated				
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only and Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due t	o the cause(s)				
	To the twithin 24	Me	29b. Signature and title of century	29c. License number	29d.	Date signed (Month,	Day, Year)				
			tree to some m	028257	(an)	9/24/	つつ				
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1	BC06-	out and				
			Tock Simon MD 13111	Coastal Ho	ghuay		1842				
	Sta		31. Date filed (Month, Day, Year) 52. Registrar's Signature 0CT 0 1 2007	West of the second	0						
	Registr	ar	OOI OI FOOL MANAGEMENT AND THE PERSON OF THE	W	~						

State of Maryland / Department of Health and Mental Hygier 17 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Willer 1:54 PM Robert September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Haspita Ba hmore (ear If Under 24 Hrs. OhNS 0 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 10M 20F 0-36-139 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State nem 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Modical Exerciter rust be notified at 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 death \ 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 Yes 2 No f Yes, Give Year or Dates: 195 White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2+ 12 UDERAFOR 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lighty or other traumatic event 2008. 17. Father's Name (First, Middle, Last) OhN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typ), Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State -28-07 Baltimore * 4 Donation 5 Dother (Specify) Bradley - Ashton Funeral Home, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11/10W SDrING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio-Respiratory Physician /Medical Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2E No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification; To 27. Manner of Death 1 Matural After t Date of Injury (Month, Day 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title My succes Charles Headorffe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 M Wolfe Street Bultimore 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

OCT 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 27 per doc 9872 10-1-07 vt.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cei	rtificate	of E	Death			Reg. No. 2	101	31	36U	
4	Physici /Medic	Hourse of roung									2. Date of Death 3. Time of Death Sept. 22, 2007 2:40a					
*	Examir		4- =99 11 22 11 12 11 11 11 11 1				4b. City, To		Spr	ing		4c. County of Death Montgor				
	Funeral Director	5. Social Security Number 224-32-0720 6. Sex 1 M 2 K F 78 Yrs. Usual Residence of Decedent						Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4 – 6 – 2	th ay, Year) 29	9. Birthp Cour Che:	olace (State of ntry) ster,	sr Foreign SC	
	the Maryland 28a-f show notified at	Director	10a. State 10b. County	1/A		Town or Lo		ode				10g. Citizen of		1 (
	h with	af Di	827 Mariet	ta Place	e, N.W.			001	1			U.S	.A.			
9036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed ♣ Decoder	ried 1 Yes If Yes, Gi Year or D	2 No ve		1 □ Yes 2 L	X No	Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	Bla	ce - Americack, White,	etc. ack		
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) James Cammon				18. Mother's Name (First, Midd Rachel Cam					,			·	
Mar	s 1 and 2 should F Health and Men tem 27 Is marke other traumatic		19a. Informant's Name/Relations Rosslyn Y. Y		ughter	1	ng Address (5 1 – 12					er, City or Towr Wash.		,		
	is 1 and 2 of Health Item 27		20a. Method of Disposition		20b. Pl		sition (Name natory or oth				ate	20c. Location				
imo	Pages ment o ant: If i		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	Line	coln (Cem			9/07	Brent				
Baltimore,	permit. Pages i Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	W. Hacfo	A.	22	Name and Hack	Address ett Up	s of Facility Shur	une:	ral Cl	napel,	Inc	•		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	each line.						r respiratory a	rrest,		Approximation Interval Bet Onset and	ween	
	Physician / /Medical		disease or condition resulting in death)	u	ute Res	_	tory	Fai	lure	2						
	eath certificate be executed attending physician and for use as the burlal-transit	Medical Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Chi</u> Due to	ronic (or as a consequ)bstru	uctiv	e P	ulmo	onar	y Dise	ease				
O. Box		Completed by Physician/Med	by Physician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live	itcome pf pregnai birth 2 □ Fetal nant at time of de iown	death 3	Ectopic preg		·				ate of deliv	-	Year
or Vital Records, P.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u			Part II. Other significant condit Septic Sh		leath but not resu	lting in the u	nderlying cau	se give	n in Part I			tobacco use coi Yes 2 □ No			
eco	e faw rec has bee je 2 shou		Coronary	Artery 1	Disease)					24a. Was		. Were auto	opsy findings empletion of o	available	
E B			Diabetes								perf	ormed? 2 X No	death? 1 ☐ Yes			
Vita	Physician: The this certificate ral director, pag	9 Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hoepital:	Inpatient 2 □ I	ER/Outrotic	at 20004	Othe	r.		(Check only		th== /C	*.1		
Division or	To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification: To	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date (Mor igation not be 28e. Place	· — —	28b. Time o Injury	f 286	i. Injury Work 1 🗆 Y		No 2	28d. Describe	idence 6 □O how injury occu Street and Num wn, State)	ırred		nber,	
	he Hospita n 24 hours he Funeral pletely fillec	Medical C		ng Physician: To the I Examiner: On the b and mar											s)	
	To t With To t	Ž	29b. Signature and title of certific	Kla	gal	my	D	License 522	number 261			29d. Date sign Sept	. 23	Day, Year) , 200	7	
			30. Name and address of person Alan R. Seg			23a) (Type, For	est G	len	Rđ.	. s.	s. Md	. 2091	0			
	Sta Regist		31. Date filed (Month, Day, Year OCT 0	4 000-	Carlstrar's Signal		best :									
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ORIGINAL

			State Registrar	e of Maryland / Departr	ment of Health and Me	ental Hygie	Z U U /	31361
	Physici	an	1. Decedent's Name (First, Middle, Last) Robert L. Your			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street an	1	. City, Town, or Location of Death	sept L	4c. County of Death	/ A
	Funeral		5. Social Security Number 6. Sex	33. 35 ()	Under 1 Year If Under 24 Hrs. a	Date of Birth (Month, Day, Ye	Sal 9. Birth	pplace (State or Foreign
	Director		2/2-28-039/ 150M 20 Usual Residence of Decedent	73 Yrs. Mc	onths Days Hours Min.)ct. 23,1	933 Nort	h Carolina
	Maryland f show	tor	10a. State 10b. County Rolling	10c. City, Town or Location	on ville			10d. Inside City Limits 1 Yes 2 □ No
	with the	Funeral Director	10e. Street and Number	ord DI	Of. Zip Code	10g	. Citizen of What Co	untry?
	ems 23	ineral	11. Marital Status 12. Was Arm	Decedent Ever in U.S. 13. Was of Forces?	Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
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21215-0036	within 72 h ene. than "netu he Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Coffee	eted) (Give kind	s Usual Occupation of work done during most of working VOT use retired)		b. Kind of Business/l	ndustry
	e filed within at Hygiene. other then vent, the Me		17. Father's Name (First, Middle, Last),	Lat	18. Mother's Name (First, Middle, Mai	OCAL A	according
Maryland	should be nd Mental markad c	To Be	Turlow Your		Maria	i Re	ddick	- Outo - 2/200
_	nd 2 ;		19a. Informant's Name/Relationship (Type, Prin. MSDeborah DeNea	1-Graves 8023	ddress (Street and Number or Rural I	th Rd	. PiKesv	ille, Md.
Baltimore	Pages 1 ar		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State 20b. Place of Disposition commetery, cremato	n (Name of ry or other place)	2007	Location - City or	Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	R1111 Jose	me and Address of Facility Ph L Russ Fu	regal t	lome, P.A	1211
l,			23a. Part7. Enter the disease, or complications shock or heart failure. List only one cause	that caused the death. Do not enter the on each line.	e mode of dying, such as cardiac or	respiratory arrest	o. Ma. 2	Approximate Interval Between Onset and Death
	Pnysician /Medical		resulting in death)	e to (or as a consequence of):	mass			2 mbs.
	Examiner	Jer		e to (or as a consequence of):				
Þ-	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	e to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	cal	d					
Вох 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med		s, outcome of pregnancy .ive birth 2 □ Fetal death 3 □Ectr	opic pregnancy		23d. Date of deli	very Day Year
P.O. I	res that the designed by the a	hysic	1 Tes 2 No 9 Unknown	Jnknown	ner (specify)			
	quires than signed and be de	þ	Part II. Other significant conditions contributing Advanced demen	to death but not resulting in the under	lying cause given in Part I.		co use contribute to	
Records,	9 4 9	Completed				24a. Was an autopsy performe	prior to d	topsy findings available ompletion of cause of
-		Be Co	25. Was case referred to medical examiner?		26. Place of Death (1 ☐ Yes 2 ☐ Check only one)	No 1 ☐ Yes	2 No
of	Phys r this rat dii	은	1 ☐ Yes 2 ☐ No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Date of Injury 28b. Time of Injury Injury	Other: 4 Nursing Home 28c. Injury at Work?	e 5 Residence d. Describe how		erfy)
Division	or Attanding Patter death. I Director: After to in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, street,	VI 1 ☐ Yes 2 ☐ No		et and Number or Ru	ral Route Number,
=	o tre		4 Hollicide	building, etc. (Specify)		City or Town, S		atatad
	To the Hospital within 24 hours a To the Funerel C completely filled	l edical	(Check only 2 Medical Exeminer: On and	o the best of my knowledge, death occ the basis of examination and/or investi manner stated.	gation, in my opinion, death occurred	I at the time, date	and place, and due	to the cause(s)
ì	To To con	ž	29b. Signature and title of certifier	mo	29c. License number D00032548		Date signed (Month	
	\		30. Name and address of person who completed	cause of death (Item 23a) (Type, Prin	h Creene Stre	et l	Baltin	ore
	Sta Registr			32. Registrar's Signature	,	- -		

			For State Registrar	State of Maryla		partment o <i>ertificate d</i>		Mental Hy	rgiene Reg. No. 2 (707	31362
W /	Ø		Negistrar Decedent's Name (First, Middle, L	ast)				2. Date of Do		Year	3. Time of Death
	Physicia /Medic	77	Thomas F. Yager	c				SEPT	. 24,	2007	1:30P M
	Examin		4a, Facility Name (If not institution, g		-2	4b. City, Tow	n, or Location of Deat	h		y of Death	
			0110111	NCAL CENT	s. last birthda	If Under 1 Ye	PLATA ear If Under 24 Hrs	8. Date of Bi	rth	9. Birth	
	Funeral Director		152-30-7675	1 M 2 □ F 6		Months Da	ays Hours Min.	Sept 1	ay, Year) 2, 1940	New	place (State or Foreign intry) Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits
	Maryls f sho ied at	ō	MD Charle	s	LaP1at	a					1 ☐ Yes 2√ No
	r 28a	Director	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of	What Cou	intry?
	th with	al D	105 Hawthorne Cr	eene Circle		2	.0646		USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Ra	ace - Ameri ack, White	ican Indian, , etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 X	No Specify:		Spec	ify: w	nite
ER 215-0036	72 hou natura ical E	ted	15. Decedent's (Specify only highest)	Education	16a. De	cedent's Usual O	ccupation one during most of wo	orkina	16b. Kind of I	Business/Ir	ndustry
元25	vithin 7	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use re salesman	one during most of wo etired)	9	auto	motiv	•
d 25	filed v Hygie ther i		17. Father's Name (First, Middle, La	st)		alesman	18. Mother's Na	me (First, Middle	e, Maiden Surna		/e
/an	ld be lental ked o ic eve	To Be	Fred Yager				Marga	ret Milu	1		
S. \	shou and N s mar	-	19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (St	reet and Number or A	lural Route Num	ber, City or Tow	n, State, Z	ip Code)
A.	and		Richard Yager/br				ne Greene		·		20646
THOM Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meonee.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Sp	Hemoval from State	cemetery, o	sposition (Name of crematory or other	r place)	Date	20c. Location	- City or I	lown, State
Balt	permit. Departi Importi any Inj once.		21. Signature of Europa Service Lin	Wade, Direct	or	22. Name and A State An Baltimor	ddress of Facility atomy Boar e, MD 212	81 ^{655 W}	. Balti	nore	Street
	4 2		23a. Part. Enter the disease, or co shock or heart failure. List or	omplications that caused the dealy one cause on each line.	eath. Do not	enter the mode of	dying, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ SEVER	E	CARD	iomy of	PATHY		1.	-2 YRS
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	y A	10 m 0 M	Dia	EASE		V00
Û.		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):	7	70107	12/3(_ 4170	-	127
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
,00	eath certificate be executed attending physician and for use as the burial-transit	I Exe	resulting in death) Last	Due to (or as a cons	sequence of):						
68760,	cate b physic the b	edical		d							
	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre					23d. [Date of deli	ivery
P.O. Box	the death certi y the attending ched for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown		3 ☐ Ectopic pregr 5 ☐ Other (speci				Month	Day Year
	w requires that the d been signed by the should be detached	by Pi	Part II. Other significant condition		resulting in th	e underlying caus	e given in Part I.				the cause of death?
ord	equire	ted t	EMPHA?	EMA				15	ØYes 2 No	3 □ Pr	obably 4 □Unknown
Sec.	e law r has be	Completed						24a. Wa	as an 24l topsy rformed?	b. Were au prior to d death?	topsy findings available completion of cause of
<u>a</u>	sician: The law certificate has b irector, page 2 s		05.14				00 Pt 4 P	1□ Yes	2 /2 /No	1 ☐ Yes	2 □ No
<u> </u>	Physician: this certifical	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Impatient 2	PITER/Outre	ntient 3□ DOA	Other:	eath <i>(Check onl)</i>	vione) esidence 6 □C	ther (Spe	cify)
ō	nding Physician: h. : After this certifice funeral director, p	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Tim	e of 28c.	Injury at Work?		e how injury occ		,
sior	Attending r death. sctor: After sy the funer	atio	2 ☐ Accident investiga	tion		М	1 Yes 2 No				
Division or Vital Records,	or Att after de Direct I in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin		it home, farm ec <i>ify)</i>	, street, factory, o	ffice	28f. Location City or 7	(Street and Nui own, State)	nber or Ru	ural Route Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		Physician: To the best of my xaminer: On the basis of exam and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier)		29c. L	icense number		29d. Date sig	ned (Mont	h, Day, Year)
4)	to any		D	-44436		SEPT	22	5 2007
			30. Name and address of person w	ho completed cause of death (Item 23a) (Ty	pe, Print) MFLLOK	CT. SUT	TE 102 1			
1		ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	north D		,		+	
	Regist	rar	OCT 0 1 2	2007	Post for	ALC: YES					

DHMH 17 Rev 1/2001

			1 - For Stele Registrar		State	of Mary	and / Depa <i>Cei</i>	artment of H	lealth ar D <i>eath</i>	nd Mental I	Hygien Reg. N		31363
ı	Physici	an	Decedent's Name (First	st, Middle, Las	')					2. Date of Month	D	ay Year	3. Time of Death
	/Medic		Mary V.	Bosley							ember		
	Examin	er	4a. Facility Name (If not in		street and nu	imber)		4b. City, Town, or		Death	4	c. County of Deal	
L			3530 Mille				1. (1.)	Stree	If Under 24	d Ure I a p	10:11	Harfor	
	Funeral		5. Social Security Number	4.0	x ∃M 2 ∑ XF		yrs. last birthday) 1 Yrs.	Months Days		Min. (Month	f Birth , Day, Yea	r) 9. Bin	thplace (State or Foreign puntry)
	Director		217-22-9229 Usual Residence of Dece	9		10)1 '''			5/13	/1906	Mar	yland
	and *			. County		100	. City, Town or Lo	cation					10d. Inside City Limits
	Aaryi r sho	ō	MD Ha	rford			Stree	et.					1 ☐ Yes 2 X No
	the N	Director	10e. Street and Number	-							10.0	Citizen of What Co	
	23a or	al Dir	3530 Mille	er Road				10f. Zip Code 21154			log. c	USA	ountry :
9500-51212	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Medical Examinar mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 🟋 🖸	100	12. Was Dec Armed F 1 Yes It Yes, G Year or I	orces? 2∭XNo ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 211 No	ispanic Origii in, Mexican, I Specify:	n? (Specify Y <i>e</i> s o Puerto Rican, <i>e</i> tc	r No-)	14. Race - Ame Black, Whit Specify:Whi	e, etc.
ş	2 hou			Decedent's Edi			16a. Dece	dent's Usual Occup	ation		16b.	Kind of Business	/Industry
2	n 7	plet		hy highest grad			(Give	kind of work done o DO NOT use retired	during most o ()	of working			·
7		Completed	Elementary/Secondary	(0-12)	College	(1-4or 5+)	Hom	emaker				Own Hom	e
	be filed tta! Hygid of other svant, II		17. Father's Name (First,	Middle, Last)					18. Mother's	s Name (First, Mi	ddle, Maide	en Sumame)	
<u>a</u>		To Be	Charles S	weeting	a .				Jos	sephine	Rigdo	n	
Maryland	should Mark	-	19a. Informant's Name/R	Relationship (T	rpe, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route N	ımber. City	or Town, State.	Zip Code)
Ξ	id 2 :		Nancy Thomp	oson/Dai	ahter			Sharon A					21050
ď.	s 1 and 2 should if Heelth and Mer item 27 is marke other traumatic		20a. Method of Dispositio		-9	20	b. Place of Dispo	sition (Name of		Date		Location - City or	
saltimore,	nt of nt of t: If it		1 ☐ Burial 2 🎇 Cre			State	cemetery, crer	natory or other plac	1	/25 /2007			
	it. P.		4 ☐ Donation 5 ☐ 0					1e Cremat . Name and Addres		/ 23/ 200 /	L	eola, PA	
g	permit. Pages 1 Department of H Important: If its any injury or ot ance.		Lephe	4,1	Li	ulle	/ 1/	rkins Fur	and the later of	Home, In	c., D	elta, PA	17314
	Physician /Medical Examiner		23 P.n1. one the dis- nock, or heart tailu Immediate Cause (Final disease or condition resulting in death)	se ve, or comp ur . List only o	a	UK	SET	2515				AD MG	Approximate Interval Between Onset and Death OVER HOW
۹	be sit	lner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Diseese or injury	ns, ate	b. Due to	(or as a cor	isequence of):	o KOM		· Ulour	SCOL	MY AISE	SE SEAN
9-	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last		c	(or as a cor	isequence ot):						
8/60,	e be e rsicien e burie	dical		l	d								
Q	ificat g phy as th	ed			<u> </u>						-		
C. BOX	w requires thet the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregrin the past 12 months 1 □ Yes 2 ₺ No 9 □ Unknown	mami		birth 2 🗀 I nant at tim <i>e</i>	Fetal death 3	Ectopic pregnancy Other (specify)			_	23d. Date of de Month	liv <i>e</i> ry Day Year
ras, r	requires thet the een signed by th hould be detache	þ	Part II. Other significant	conditions co	ntributing to d	leath but not	resulting in the u	nderlying cause give	en in Part I.			. /	o the cause of death? robably 4 Dunknown
Hecol	a 20	ompleted								_ _ ;	Mas an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital		C	25. Was case reterred to	medical					26 Place o	1 □ Y of Death (Check o		10 103	2010
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🗗 No		Hospital:	Inpatient	2 ER/Outpatien	t 3 DOA Othe	ac			6 ☐Other (Spe	scitu)
5	9 Ph		27. Manner of Death		28a. Date	of Injury	28b. Time of					jury occurred	(any)
5	th. After	ê l	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Mor	nth, Day Yea	r) Injury		<br Yes 2∐No	0			
UNISION	or Attai frer dea fractor	ertification:		Could not be determined	28e. Plac	e of Injury ling, etc. (Sp	At home, tarm, str	eet, factory, office		28t. Locati City o	on (Street a Town, Sta	and Number or Ri	ural Route Number,
	To the Hospital or Attanding Physic within 24 buous after death. To the Funeral Director. After this co completely filled in by the funeral director.	edical Ce	CHECK OTHY Z	Certifying Phy Medical Exem	ner: On the t	asis of exar	knowledge, death	n occurred at the time	ne, date and pointion, death	place, and due to	the cause	(s) and manner as	s stated.
	To the within 2 To the complet	Med	Olie)		and mar	ner stated.							
			30. Name and address of	person who c	C Vo	se of death	(Item 23a) (Type,	My UD (0163	89	54	TEMB	FR 22, 2007
	Ч		PERFECTO	C. V	MAR	AO K	10 17/1	5 ItAR FO	LO R	d Su. 10	75 F	MISTON	4021047
	Sta Registr		31. Date tiled (Month, Da	y, Year) 0 1 200	1 Sept	Registrar's S	ignature	dis					th, Day, Year) GR 22, 2607 (HO 21047

State

Registrar

ess of person who

Year)

2

£ 2007

31. Date filed (Month, Day,

ted cause of death (flem 23a) (Type, Print)

32. Figistrar's Signature

			For State Registrar	State of M	arylan		artmen rtificate			and M	ental Hy	giene Reg. N2	007	3136	5
	Physici	an	1. Decedent's Name (First, Middle,	Last)			3a; le	·U			2. Date of Dea	Day	Year	3. Time of Death	
1	/Medic		4a. Facility Name (If not institution,	rive street and number)					Location o		poptombon	`	ounty of Dea		
	Examin	ier	Johns Hopkin						one						
	Funeral Director					ast birthday) Yrs.	-		If Under : Hours	24 Hrs.	8. Date of Birt (Month, Da AUG 1	7 194	9. Bir	thplace (State or Fore buntry) MD	eign .
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Lim	nits
	Maryla I-f shor	ţ		GOMERY		ICKER								1 Tes 2 1	2
	ath with the Marylan 23a or 28a-f show ust be mailited at	Funeral Director	10e. Street and Number 18601 WASCHE	BOYD			10f. Zip	Code 0842)			10g. Citize	n of What Co	ountry?	
	eath rs 23	eral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.				gin? (Spe	cify Yes or No	- 14	Race - Ame	erican Indian,	
936	urs after d	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	2		If Yes, spec 1 ☐ Yes		Specify:	, Puerto	cify Yes or No Rican, etc.)		Black, Whit		
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show Ita M. Jical Ex. nither i. ust b. natified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give	dent's Usua kind of wo DO NOT us SEWII	rk done d se retired	luring most	t of workii	ng		of Business		
7	T3 (70 % ****		10			1100			10 Matha	- Nama	(First, Middle,				
yland	e d a b	To Be	17. Father's Name (First, Middle, La RALPH EMBRI	CY					DOF	ROTH	Y GRAN	T		7.011	
Mar	d 2 sh th and 7 is m traum	6	19a. Informant's Name/Relationship GEORGE T. BAII		3						I Route Number				
ē,	s 1 and if Health item 27 other tra	18	20a. Method of Disposition			lace of Dispo emetery, crei	sition (Nan	ne of			ate			Town, State	
Ë		1	1 ☐ Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe			RKLAW				9/1	9/07	ROC	KVIL	LE, MD	
Balti	permit. Page Department Importent: If any injury o		21. Signature of June : envice in	censee		2	Name an HILT(P.O.	d Addres ON F BOX	UNER	XAL BA	HOME RNESVI	LLE,	MD	20838	
			23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that cause only one cause on each I	d the deatl ine.	h. Do not en	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Pnysician	9 7	Immediate Cause (Final disease or condition	a. A3	inzt	FON F	noum	on i	A					2 2043	
	/Medical Examiner		resulting in death)		a conseq 2 h o si									3 45	_
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as										3 (113/1/1)	
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. (no)	a conseq	D: 3003 uence of):	C-							3 months	5
8760,	± ≥ 0	icai		d											
O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fete	death 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of de Month	slivery Day Year	
ls, P.O.	res that the de signed by the a be detached	þ	Part II. Other significant condition	s contributing to death I	but not res	ulting in the u	inderlying c	ause give	en in Part I					to the cause of death	
Sorc	w requir been si should	etec							_		24a. Was	an	24b. Were a	utopsy findings availa	able
Vital Records,	The law ate has page 2	Completed									auto			completion of cause	
ital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	-			
<u></u>	d is	2	1 ☐ Yes 2 💆 No	Hospital: 1 Anpati	ient 2 🗆	ER/Outpatie	nt 3 DC	OA Oth	er: 4□Nu		me 5 Resi			ecify)	
Division of	ding h. After fune	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		ury ay Yea <i>r)</i>	28b. Time o Injury	of M	8c. Injun Worl 1 ☐ '	/at <br Yes 2□		28d. Describe	how injury	occurred		
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of II	ijury - At ho tc. <i>(Specif</i>	ome, farm, st y)	reet, factor	y, office			28f. Location (City or To	Street and wn, State)	Number or F	Rural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical (Physicien: To the bes keminer: On the basis and manner s	of examina										
	To th withir To th comp	Me	29b. Signature and title of certifier				29		e number				•	nth, Day, Year)	
			Deott CNAthuri	5, Medical 1				Re	5-0	00		Scoto	mber	14, 2007	L
(5		30. Name and address of person w	ho completed cause of	death (Iter	n 23a) (Type	Print)	.,	1 - 10	. A.L	. 1 . 1		m 1	1 21227	
	Sta	ate	31. Date filed (Month, Day, Year)	50hn 5 Hopk, 2007	つう Ma trar's Signa	ature	600)	Vorth	WOIF	COTTO	BOT, Balt	more	riorylan	0 21207	
	Regist	rar	SEP 18.	ZUUT DELL	1	~ M									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#10eperFH9/26/07, BMW, MoCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Marguerite Therese Berger Month 2007 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 1 □ M 2 F Director 60 Jan. 19, 215-52-6008 DC 1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 SYes 2 □ No Funeral Director Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Wickshire Way 20852 United States 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Nolan 2 Benita M. Gormley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. <u>Nolan - Brother</u> 7503 Lynn Dr. Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State National Crematory Sept. 18,07 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760 80 Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ached 0 9□Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe page death? 1 ☐ Yes 2 No 1 Tes 2√2 No 25. Was case referred to medical 3 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2K ER/Outpatient 3 □ DOA Margine 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical S 29b. Sid 29c. License number 29d. Date signed (Month, Day, Year) 5 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas MD 11510 Old Georgetown Rd. Rockville, MD 20852

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Otate of Maryland		tificate of D	Death	Reg. No	2007	31367
	Physicia		1. Decedent's Name (First, Middle, La	A -		T	2	Date of Death Month Da		3. Time of Death
	/Medic	al _	James	H. Barn	es	4b. City, Town, or l	ocation of Death	9-17-	. County of Death	6:35 PM
î. Î	Examin	er	4a. Facility Name (If not institution, giv Hartley Ha	1.1		Pocamo	1 0.1		Worces	1
Spirit	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day, Year)	9. Birth	place (State or Foreign intry)
Ŀ	Director		290-01-9046	1 © 43	Yrs.			8-29-192	4	<u>"MD</u>
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh ified a	ctor	VA Accom	rack Ch	incot	eague				1 ☑Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code	336	10g. Cit	tizen of What Cou	ntry?
	eath w	Funeral Director	5122 Screnit	y Lane 12. Was Decedent Ever in U.	S. 13.		spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ameri	
(0	after d		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 May Yes 2 □ No If Yes, Give		If Yes, specify Cubar 1 □ Yes 2 ⊠ No	n, Mexican, Puerto Ri Specify:	can, etc.)	Black, White,	, etc.
<u>ල</u>	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ith, the Medical Examiner must be notified at	Completed by	3 X Widowed 4 ☐ Divorced	Year or Dates: WW.	11			16b K	(ind of Business/Ir	ndustry
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212	d withi	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Constru				or Vehicle
밀	be filed tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last				18. Mother's Name (
Maryland 21215-0036	should be and Mental is marked o	2	James H. 19a, Informant's Name/Relationship	Barnes (Time Print)	19h Mailii	ng Address (Street a	Mary and Number or Tural	J. Edw.		ip Code)
<u>≅</u>	and 2 st ealth and n 27 Is n		Roy Landis	Son	512	a Sere	. 1			VA 2336
re,	item	Ì	20a. Method of Disposition	20b. F	Place of Disponentery, cre	osition (Name of matory or other place	e) Da			
<u><u>E</u></u>	Pages ment of t ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	ity) Occi		k Cremato			cmore, l	1A
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at angre.		21. Signature of Funeral Service Lice	nsee	2	2. Name and Addres		chi	a7 Chur	JUP, UA 23336
	20200		23a. Part1. Enter the disease, or cor	nplications that caused the deal	h. Do not en	ter the mode of dying	neral Hom g, such as cardiac or	respiratory arrest,	a i Chui	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each line.		4.4	lerosis		1	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a cons						
	Examiner	_	Sequentially list conditions,	b. Due to (or as a conseq	uence of):					
	uted I Insit	Examiner	Sequentially list conditions, the last not to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2						
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			IF FEMALE:	23c. If yes, outcome pf pregna					23d. Date of deli	ivery
. Box	The law requires that the death cer te has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2□Feta		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
P.O.	at the by the	hys	9 Unknown	9□Unknown	ulting in the	underheime souso eine	on in Part I	23e Did tobacco	use contribute to	the cause of death?
	w requires that been signed to should be deta	by	Part II. Other significant conditions	contributing to death but not res	sulting at the t	andenying cause give	en in raiti.	1	_	obably 4 Unknown
Cor	w requ	Completed						24a. Was an	24b. Were au	utopsy findings available
Re	The law cate has page 2 s	omp						autopsy performed? 1 Yes 2 2	death?	completion of cause of 2 □ No
ita	Ø 57	BeC	25. Was case referred to medical examiner?			- Lou	26. Place of Death			
or V	ys dili	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie	ent 3 DOA Oth	4 Nursing Hon	ne 5 Residence 8d. Describe how in		cify)
On (ding I h. After funer	tion:	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,	
Division or Vital Records,	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine		! lome, farm, s ify)	treet, factory, office	2	8f. Location (Street a City or Town, Sta	and Number or Ruate)	ural Route Number,
Ö	ital or urs afte ral Dir	Cert		2			me date and place (and due to the equipe	(c) and manner as	e stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	ation and/or i	investigation, in my	opinion, death occurr	ed at the time, date a	and place, and due	to the cause(s)
	To the within 2	Me	29b. Signature and title of dertifier	Con		29c. Licens			Date signed (Mont	
) Jane	I SARAD R.	BAR	AU D 5	4422		9-17-	07
P	5A 10+1		30. Name and address of person wh	t (+ 1)-		100	MD	21851		
-		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1		2.001		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 7 31368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:14 PM naron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marylan Baltmore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. 1 □ M 2 🗸 F Days Hours Director MARYLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 □ Yes 20 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KNOWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stitting hûm an 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation
4 □ Donation 5 □ Other (3 Removal from State PRING HILL Memory 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Ente the disease shock, or he he allu be Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 □ Pregnant at time of death 9 □ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 21 No 1 🛮 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy w performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Greene ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

13

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1 per PHYS G872 10/1/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Eva Clow Month Day 9/22/2007 **Physician** 12:15 AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Frederick Airy Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 1 F Director 9/15/1955 MD 219-66-3652 52 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner must be notified at 1x Yes 2 No MD Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 Broadway Street 21701 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Respiratory Therapist <u>Medical</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic 2 William R. Clow Sr Clara Schenck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Health a 207 St. Matthew Ct Westminster, MD 21158

Date 20c. Location - City or Town, State permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. <u>William R. Clow Sr.</u> Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Cremation: 9/23/2007 | Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Septice License 106 East Church Street Frederick, Maryland 21701 MO1176 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULTIPLE SCLEA **Physician** linkn.wa disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the at d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has t irector, page 2 s autopsy performed' To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Pother (Specify) (4) (1) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: illed in by the funera 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 1 2007

32 Registrar's Signature

KVIEW

			1 - Stata Registrar	State of Marylar		artment rtificate				Reg. No.	7 3	31370
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last	M COUL	EHAN				2. Date of De	18-3	201	3. Time of Death
	Examir	ner	4a. Facility thame of restriction gives	HOTEL HOR	last highday)	-	NTSI	ILLE Judge 24 Hrs.	M D	4c. County o	eren	(State of Faring
	Funeral Director			M 2□F 95	Yrs.			ours Min.	8. Date of Bir Feb 2,	1912	Couvin	e (State or Foreign
	a Marylanda-f ehow	ctor	MD 10a. State Allegan		ty, Town or Lo						10d.	. Inside City Limits 1)√ Yes 2 No
	ath with the 23a or 28 ust be no	rai Dire	10e. Street and Number 603 North First St.			10f. Zip 0		502		10g. Citizen of Wh		?
980	n 72 hours aftar daath with tha Maryland "naturel", or iteme 23s or 28s-f show policel Examinat must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede If Yes, specifi 1 ☐ Yes 2	(nic Origin? (Sp exican, Puerto ecify:	ecity Yes or No Rican, etc.)		- American , White, etc white	
Maryland 21215-0036	i within piana. r than "	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use	done during	g most of work	ing	Spice Co		try
/land	Mantal Hygis Mantal Hygis arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last) Bernard J. Coule	han					e (First, Middle anks Co	, Maiden Sumame oulehan)	
	d 2 sho th and 7 le m traum		19a. Informant's Name/Relationship (Ty Sheila Rowe	daughter						er, City or Town, S nond		
Baltimore,	or or		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Hill	Place of Dispo cemetery, crer Crest Me	matory or oth morial F	ark	1 1 1 4	Date 9/25/2007	20c. Location - C	-	MD
Bal	parmit. Pa Dapartman Important: eny injury		21. Signatur of Fineral Service Licens	MAM		108	Virginia		: Cumbe	rland, MD 2	1	
30° m	Physician and businers and businers and suppression and suppressions are suppressions and suppressions and suppressions are suppressions are suppressions and suppressions are s	I Examiner	23a/Part. Enter the disease, or complications speck, or heart failure. List only/or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	ne cause on each line.	AGE (uence of): CRA (uence of):					SCASE	In	pproximate terval Between nset and Death
P.O. Box 68760,	daath cartif a attanding d for usa a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	I death 3	⊒Ectopic preg] Other (spec				23d. Date Mont		y Year
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Division of Vital Records,	To the Hospital or Attending Physician: Tha I within 24 burus aftar death. To the Funeral Director: Aftar this cartificata ha complataly filled in by tha funaral director, paga	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		1	Nursing Ho		one) dence 6 ⊡Other how injury occurred		
Divis	s after des s after des al Director ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, o	office		28f. Location (City or To	Street and Number wn, State)	or Rural R	oute Number,
	To the Hospital within 24 hours a To the Funeral I complataly filled	edicai	29a. Certifier 1 Cartifying Physic (Check only one) 1 Medical Examination 1	sician: To the best of my knower: On the basis of examination and manner stated.	wledge, death	n occurred at vestigation, in	the time, da my opinion	ate and place, n, death occurr	and due to the red at the time,	cause(s) and mani date and place, ar	ner as state ad due to the	d. e cause(s)
i	To I To I	Σ	29b. Signature and title of certifier	Pmp			icense num	423	/	29d. Date signed	(Month, Day	r, Year)
	13		KOBIN BISSE	ompleted cause of death (Iter	124	Print)				SVILLE	MD	21536
	Sta Registr		31. Date filed (Month Day Year) 2007	32. Registrar's Signa	iture							_ *

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, Line c. perPHYS. G872, 10/1/07 WS
State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Barbara Jean Coyle September 23 2007 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 21X F Director 219-36-2847 68 11/22/1938 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Exaπiner must be notified at Director N Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 East Ninth Street 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes A ☐ No Specify þ Specify: 3 ☐ Widowed 4 X Divorced White the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 Education other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ' 1 an. of Health an. * tem 27 is mark. ➤ traumatic ev P <u>Claude L. Crampton</u> Dora K. Crone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Georgia A. Smith Daughter <u>1727Cosner_Road_Foresthill_MD_21050</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/26/2007 | Middletown, Maryland Middletown Luth, Cem: 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Keeney & Basford P.A. F.H. 4.6 106 East Church Street Frederick, MD 21701 M01176 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 18hr /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit proat Ton Pneumonia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🔲 Yes 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) Natural Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendential 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0 35106

Registrar

10

State

Myung

31. Date filed (Month, Day, Year)

OCT 0 1

<u>400 W. 7th Street Frederick, MD 21701</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

Nam

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 8, 2007 4:45 Robinson Philip Commodore Andrea Sharon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🕅 I 60 579-62-4110 Director 21, 1946 Washington, DC \$ept. Usual Residence of Decedent 10c. City, Town or Location f show 10a. State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 20906 3511 Forest Edge Drive United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any inluy or other traumatic event, the Medical Examiner ones. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: African American Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) English Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Thomas Robinson Imogene Beulah Garnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Burton Commodore / Spouse Forest Edge Drive, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 9/17/2007 Brentwood, Maryland 21. Signature of Funejal Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, di sho k, or heart failure. List Immedia e cause (Final r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Lung Physician CARCINOMA disease or condition resulting in death) SMALL CELL /Médical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of) or Vital Records, P.O. Box 68760,

sician and burial-tran ate has been signed by the attending physician page 2 should be detached for use as the buria within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

Physician/Medical Completed 25. Was case referred to medical examiner? Be 1 🗌 Yes 2 27. Manner of Death Certification: 1 Natural 2 ☐ Accident

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death

5 Other (specify)

3 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown

24a. Was an autopsy perform

MD

23d. Date of delivery

Month

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

Day

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred

(Month, Day Year) 5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and t ertifier

29c. License number 35 635

DLNEY.

29d. Date signed (Month, Day, Year) SEPTEMBER 4005, PO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince JOSEOH Kmcm

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 1 8 2007

32. Reistrar's Signature

Division

To the Hospital or Attending

within 24 hours a

To the Funeral I

Certificate of Death

Reg. No

2:10 P M

WASH. D.C.

BLACK

10d. Inside City Limits

Yes 2 No

DHMH 17 Rev 1/2001

State Registrar 32. Pojistrar's Signature

/Medi	ian	1. Decedent's Name (First, Middle, Last) Jirong Dai			2. Date of Death Month Day September 15,	Year 2007 3. Time of Death
Examir		4a. Facility Name (If not institution, give street and number)		or Location of Death	4c. County	
والتعوي عدادة		11773 Skylark Road 5. Social Security Number 6. Sex 7. Age (In y.	Clarks rs. last birthday) If Under 1 Year			gomery
Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In y. 68 1 M 2 □ F 68 68 68 68 68 68 68	7/	Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 27, 1938	9. Birthplace (State or Foreig Country) China
at			City, Town or Location			10d. Inside City Limits
a-f st	ctor	Maryland Montgomery	Clarksburg			1 ☐ Yes 2X No
or 28 e not	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Country?
s 23a nust k		11773 Skylark Road		0871	Chi	
it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spec oan, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.) 14. Rac Bla	ce - American Indian, ck, White, etc. ^{iy:} Asian
natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu	pation	16b. Kind of B	usiness/Industry
jiene. r than " the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 4	(Give kind of work done life. DO NOT use retire Teacher	d)	Educa	ation
and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last)			First, Middle, Maiden Surnar	,
Men narke	은	Pincheng Dai	T	1	known Yuying	
th and		19a. Informant's Name/Relationship (Type. Print) Jiang Zhou – Wife	11770		Route Number, City or Town	, State, Zip Code)
Health tem 27 other tr	-	20a. Method of Disposition 20b	p. Place of Disposition (Varies) of cemetery, crematory or other places are tropical errors of the control of t	k Road C	Tarksburg, MI	20871 - City or Town, State
ent of at: If it y or o		1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crematory or other plants	09/18	8/07 Beltsvi	
Department of Important: If any injury or once.		21. Signature of Funeral/Service/Licensee		ess of Facility Goin 1-Williams	g Home Cremat P.A., Funeral	Tarketh
ysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a cons	ral pleural	effusi	on	Approximate Interval Between Onset and Death
uphysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a out cause). Due to (or as a constitution of the con	equence of):	-))		6 mont
attending physician and for use as the burial-trar sit	edical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of): equence of): gnancy etal death 3 Ectopic pregnance		23d. Da	de of delivery
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not reconstructions.	equence of): equence of): gnancy etal death of death of death of the underlying cause given.	y	23d. Da Mo	tribute to the cause of death?
has been signed by the attending physician and je 2 should be detached for use as the burial-transit	Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not represent the property of the pregnant and the present of the pregnant and the present of the	equence of): equence of): gnancy etal death of death of death of the underlying cause given.	y	23d. Da Mo 23e. Did tobacco use com 1 ☐ Yes 24a. Was an autopsy performed2	te of delivery onth Day Year tribute to the cause of death?
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar sit	Be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not represent the property of the propert	equence of): eq	y ven in Part I. 26. Place of Death (23d. Da Mo 23e. Did tobacco use com 1 Yes No 24a. Was an autopsy performed? 1 Yes No Check only one)	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Wher this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-trar sit	To Be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No No 9 Unknown Part II. Other significant conditions contributing to death but not represent the past of the pregnant at time of	equence of): eq	y/en in Part I. 26. Place of Death (incr. 4 \square Nursing Home ty at the control of the	23d. Da Mo 23e. Did tobacco use com 1 Yes No 24a. Was an autopsy performed? 1 Yes No	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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arm. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not represent the past of the pregnant at time of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of polynomial properties. The prediction of polynomial properties are predicted by the prediction of prediction of prediction of prediction of prediction of polynomial properties are predicted by the prediction of predic	equence of): eq	y/ven in Part I. 26. Place of Death (her: 4 \sum Nursing Homery at k?) Yes 2 \sum No 28	23d. Da Mo 23e. Did tobacco use com 1 Yes No 24a. Was an autopsy performed? 1 Yes No Check only one) 2 Residence 6 Oth d. Describe how injury occur of. Location (Street and Numb. City or Town, State)	te of delivery onth Day Year tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ner (Specify) red
arm. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	equence of): eq	y y y y y y y y y y y y y y y y y y y	23d. Da Mo 23e. Did tobacco use com 1	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ner (Specify) red per or Rural Route Number, anner as stated, and due to the cause(s)
or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-trar sit	Certification: To Be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	equence of): eq	y y y y y y y y y y y y y y y y y y y	23d. Da Mo 23e. Did tobacco use com 1	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ner (Specify) red per or Rural Route Number, anner as stated, and due to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month SEPT 16 2007 2007 1. Decedent's Name (First, Middle, Last) ROBERT HENRY DEGROOT 16, 4b. City, Town, or Location of Death Bettlesda u 4c. County of Death Man Former 4a. Facility Name (If not institution, give street and number) MO centre 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Wrs. Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country)

Division or Vital Records, P.O. Box 68760.

1 - For State Registrar

Physician

/Medical

Examiner

Funeral

Director		310-40-7132	/ _	_ ¢ 7			May 14	1,1940 C	olorado
and w		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town	or Location				10d. Inside City Limits
ie Maryl 8a-f sho tiffied al	Director		gomery		ville				1 X Yes 2 No
vith th	Dire	10e, Street and Number 1007 Aster B	1		10f. Zip Code		1	0g. Citizen of What C	ountry?
s 23a nust i	eral				20850			USA	
uus after de al', or item Examiner r	by Funeral	11. Marital Status 1 □ Never Married 2X Mar 3 □ Widowed 4 □ Divorced	If Yes Give		 Was Decedent of Head of Fig. 1. Yes, specify Cub Yes 2 No 		Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Man yielitu Z I S-UU30 d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "hatural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5	(Pecedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of w d)	orking	16b. Kind of Busines	
filed v Hygie thert		17. Father's Name (First, Middle,			Presider		ame (First, Middle, M		mental Co.
ylalli ould be Mental arked o	To Be	Henry DeGroo	t			Eliza	beth Vic	let Spac	
nd 2 alth a 27 is		19a. Informant's Name/Relations Carolyn DeGr			Mailing Address <i>(Street</i> 007 Aster				
permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State	20b. Place of D	Disposition (Name of crematory or other plate plate)	ce)	Date	20c. Location - City o	r Town, State
permit. Departimporti		21. Signature of uneral Service	wolks		PHILIP D.	RINALD:	I FUNERA	L SERVIC	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do not	t enter the mode of dyir	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Cardi	opulm	enny 7	En l'ure			Onset and Death
Examiner		Sequentially list conditions,	, Hepat		try /	que do	anneysu	n hemm	ge 24h.
cuted Id	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	s but	c neur	aend	otune	Former	ge 24h.
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	a consequence of)					
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date of de Month	l slivery Day Year
w requires that been signed to should be dete	þ	Part II. Other significant condition Acute Clu	days to death bu	nt not resulting in the	_ , /	en in Part I.		\sim	o the cause of death?
9e	Completed						24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of
cian: ertific ector,		25. Was case referred to medical examiner?				26. Place of De	ath (Check only one		, 2010
Physi this o	은	1 Yes 2 No	Hospital: 1 Inpatier			4 LI Nursing I	1	nce 6 ☐Other (Spe	oify)
Attending Physician: r death. ector: After this certific by the funeral director,	ation:	27. Manner of Ceath Natural 5 Pendin and investig	ation	y 28b. Tim <i>Year)</i> Inju	ry Wor	yat k? Yes 2 ∐ No	28d. Describe hor	w injury occurred	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification:	3 Suicide 6 Could r 4 Homicide determ	28e. Place of injuiding, etc.	ry - At home, farm . (Specify)	, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
the Hospital or hin 24 hours afte the Funeral Dir πpletely filled in	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of Examiner: On the basis of and manner stat	examination and/o	eath occurred at the tir or investigation, in my o	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
15 N E E E	Σ	29b. Signature and title of certified	Pumil 1	ns	29c. License	number 055945		d. Date signed (Mon	
			who completed cause of de	./ \		DRIVE	BETHES		0892
Stat		31 Date filed (Month Day Year)	32. Figistra	r's Signature	,			-19 110 2	3074
Registra		061.1	, LOUI JOSE	n b,	garle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.0.0

		•	For State Registrar		Olalo ol	mary ia	(Cert	ificate of	Death	Mental 115	Reg. No		37	3137	6
Phy	sicia	n	1. Decedent's Name (Fin	st, Middle, La				J.		_	2. Date of D Month	eath Da	ay Ye	ear	3. Time of Death	
	edica	d	4a. Facility Name (If not	institution aiv		سرح کرایم				r Location of Deat	09	16	こ County of I		2.0- PN	1
Exa	mine		Coastul H		a+ 17	c (do		S. F.S.	bury	ш	40	Wi c		S ===	
Fune	ral		5. Social Security Number	er 6. S	ex 7	Age (In yr	s. last birtho		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth	9.	Birthpla	ace (State or Foreigny)	ın
Direc	tor		124-24-6348 Usual Residence of Dece	,	X M 2□F	7.5	Yn	s.	IVIOTICIS Days	TIOUIS WIIII.	11/13/	1931	Ĺ	Counti	NY	
land ow		-		. County		10c. 0	City, Town o	or Loca	ition					10	d. Inside City Limits	
Many a-f sh		ğ	MD W	lorcest	er		Oce	an	Pines						1 ☐ Yes 2 ☑ No	
th the or 28%		Director	10e. Street and Number				000	un.	10f. Zip Code			10g. Ci	tizen of Wha	t Count	ry?	
ath w			3 Ash Cour	t					218				USA			
ter de items		Funeral	 Marital Status Never Married 	≫ Married	12. Was Deced Armed Ford 1 ☐ Yes 2	es?	U.S.	13. Wa	as Decedent of H res, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	0-	14. Race - / Black, V			
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examiner must be notified at		2	3 ☐ Widowed 4 ☐ I		If Yes, Give Year or Dat			1 🛭	⊇Yes 2XINo	Specify:			Specify:	Whit	:e	
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Illed v Hygie Ither t			17. Father's Name (First,	Middle Last)	4			Com	puter Pr	ogramme 1 18. Mother's Nar			Shippi:	ng		
aryland 2121; should be filed within and Mental Hygiene, s marked other than "umatic event, the Mer	Ġ	0 26	John J. D								ine Fies		,			
ary shou and M s mar	١	-	19a. Informant's Name/F				19b. M	lailing	Address (Street a	and Number or Ru				te, Zip (Code)	
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Ore, ges 1 au of Hea if item			20a. Method of Disposition 1		Removal from St		Place of Di cemetery,	ispositi <i>crema</i>	ion (Name of tory or other plac	e)	Date	20c. L	ocation - City	or Tow	/n, State	_
Dailimor Dermit. Pages Department of mportant: If its any injury or o			4 □ Donation 5 □	Other (Specify)		r Lad			Cem 9/2					·Α	
DENKIMOTE, MATYIANG Z1Z15-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if ifem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumatic event, the Medical Examiner must be notified at	опсе.		21. Signature of Funeral	Service Lieen	see Ha	-1				ss of Facility Bu				ne		
_ 22 _ %	*	+	23a. Party. Enter the dis	sease or com	lications that car	sad the dea	ath Do not			am St.,			21811		Ammorianata	_
Physicia		14	Immediate Cause (Final	ure. List only	one cause on each	h line.	1.	1/	the mode of dyin	g, such as cardiac	c or respiratory a	ırresı,			Approximate Interval Between Onset and Death	
Physicia // /Medic	_		disease or condition resulting in death)		a. Due to (or	as a conse	equence of):	a	cano							_
Examin	er	1			Duo to (o i	us a consc	squemoc ory.									
₽ #		5	Sequentially list condition cause. Enter Underlying Cause (Disease or injury	ns,	Streets (or	ds a nur.s	querice of):									_
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oo/ou, rificate be executed ng physician and as the burial-transit	Modical				d											_
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requires the een signe nould be d	2	2	Part II. Other significant	conditions of	ontributing to dea	n but not re	suiting in th	e unae	erlying cause give	n in Part I.	23e. Did t		,		cause of death?	
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he lav e has	1	-									24a. Was auto		24b. Were prior deat	to comp	sy findings available pletion of cause of	t
	a) :	25. Was case referred to	medical						26. Place of Dea	1□ Yes	No	10	Yes 🕰	Mo	_
ysici nysici nis cer direc	ToB		examiner? 1 ☐ Yes 2☐ No		Hospital:	atient 2] ER/Outpa	tient	3 DOA Othe		lome 5 ☐ Resi	+-/	6 □Other (5	Specify)		_
Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director,			27. Manner of Peath	Pending	28a. Date of (Month,	njury Day Year)	28b. Tim-		28c. Injury Work		28d. Describe					
ttendi leath. tor: /	ites		2 Accident	investigation Could not be	00. 51					res 2 □ No						
after of Direction by	Certification.		4 ☐ Homicide	determined	building	etc. (Spec	ify)	street	, factory, office		28f. Location (: City or To	Street an vn, State	d Number o	Rural I	Route Number,	
spita nours neral			29a. Certifier	Certifying Phy	rsician: To the be	st of my kn	owledge, de	eath o	ocurred at the tim	e, date and place	and due to the	cause(s)	and manne	r as sta	ted.	\dashv
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	edical		(Check only 2 N	Medical Exam	Iner: On the bas and manne	s of examin	ation and/o	r inves	stigation, in my op	pinion, death occu	irred at the time,	date and	d place, and	due to t	he cause(s)	
Withi To the	Ž		29b. Signature and title of	f certifier	MI	. ^ ~			29c. License	number		29d. Dat	te sign <i>e</i> d (M	onth, D	ay, Year)	
			CANE	2	24	70			100	6278		- (1-17-	0	7	
15+1		3	0. Name and address of	person who c	ompleted cause	of death (Ite	m 23a) (Typ	Prin	River!	777	C. Lul	. 1	IA :	210	01	
	State	;	31. Date filed (Month, Day	y, Year)	32. Re	strar's Sign	ature_		JAXI,	133	201/50	, 1	1 6	10	<u> </u>	_
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DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Division

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911 ellian 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** September 2007 Emma Paul Edger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ambridge Dorchester Genera If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F Director 220-32-1534 Maryland 3, 1935 Jan. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 116 Willis Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 🔀 No Specify: white \mathcal{E}_{MMac} \mathcal{L} \mathcal{C}_{dge} Baltimore, Maryland 21215-003(<u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 office manager auto dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F. Be Pages 1 and 2 should be Calvin Paul Naomi Travers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Leigh B. Edger husband 116 Willis St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/11/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute M 10 Condial disease or condition resulting in death) /Medical Examiner Severe ANOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atten 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autonsv performed' 2 LNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred al or Attending Patter death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D

State Registrar

Medical

31. Date filed (Month, Day, Year)

NOMAIN

29b. Signature and title of certifie

29a. Certifier

32. Rg

MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 1 3 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 47924

29d. Date signed (Month, Day, Year)

9-12-07

21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month September 14, 2007 Minnon 5:25 Friedman Hirsch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9603 Merwood Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 219-36-8119 1 M 2 XF 99 Director Nov. 17, 0klahoma 1907 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f sh aminer must be notified Director Maryland Montgomery Silver Spring 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be not private that the medical Examiner must be not be the statement of the Medical Examiner must be not be the statement of the medical Examiner must be not be the statement of the sta 20901 United States 9603 Merwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2K No Completed by Specify: 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Hirsch Florence Hirsch ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence F. Rosenblum/Daughter 3306 Kent Street Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 09/16/2007 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Hebrew Cemet. Washington, DC 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Lienne 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and D Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burlal-transit Due to (or as a consequence of) Box 68760. nding physician 99 Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 1□ Yes 2 🔯 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TR Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

State

(Check only one)

Barry N.

29b. Signature and title of certif

31. Date filed (Month, Say Year) 8

Rosenbaum MD 3720 Farrugut Ave. Kensington, MD 20895

29c. License number

D09834

29d. Date signed (Month, Day, Year)

September 14, 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Of Mile Registrar	aryland / L	•	e of Death		Reg.	7000	31380
*	Physicia		1. Decedent's Name (First, Middle, Last)	GOIN	a C			Date of Death Month	Day Year	3. Time of Death p 23:43 M
	/Medic Examin		JAMES FRANKLIN 4a, Facility Name (If not institution, give street and number)	0.	4b. City,	Town, or Location			4c. County of Deat	h
. 19			FENINSULA KEGINAL MEDICA 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bir	rthday) If Under		r 24 Hrs. 8. I	Date of Birth	WICA ME	hplace (State or Foreign
	Funeral Director		228-56-0093 1໘M 2□F Usual Residence of Decedent		Yrs. Months	Days Hours	Min. A	Month, Day, Yeugust 19	O 1003	Virginia
	yland how at		10a. State 10b. County	10c. City, Tow	n or Location					10d. Inside City Limits
	he Ma 18a-f s	Director	Maryland Somerset		10f. Zip	Crisfie	eld	100	Citizen of What Co	1 ☐ Yes 2 ☒ No
	th with t		2840 Calvary Road		101. 21	21817	7	109.	USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Sive Year or Dates:	•	13. Was Decei if Yes, spe 1 \(\text{Yes}	dent of Hispanic Ocify Cuban, Mexica 2X No Specify		Yes or No- an, etc.)	14. Race - Ame Black, Whit	
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Baltimore, Maryland 21215-0036	Pages 1 nent of Hi int: If Iter		20a. Method of Disposition XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemete	of Disposition (Nai ery, crematory or c lk Primitiv	other place)	Date Cemeterv		c. Location - City or Claudevill	le, Virginia
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Mary Beth Bradshaw-Pru	Butt	22. Name ar	nd Address of Faci	lity BRAD	SHAW &	SONS FUNE	RAL HOME
,			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do	not enter the mod	le of dying, such a	s cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death
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Division or Vital Records,	The law req	Completed	atrial fibrillation					24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings available completion of cause of
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or	Physical this caral direction	: To	27. Manner of Death 28a. Date of Inj	ury 28b.	utpatient 3 D	28c. Injury at Work?		5 Residence Describe how	e 6 □Other (Spe injury occurred	ecify)
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Divis	al or Atter de safter de l'Directe	Certification:		jury - At home, fa tc. <i>(Specify)</i>	arm, street, facto	y, office	28f.	City or Town, S		iural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis and manner s	of examination a	ge, death occurred and/or investigation	d at the time, date n, in my opinion, d	and place, and leath occurred	due to the caus at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifler		29	ic. License number		29d	Date signed (Mon	nth, Day, Year)
•			30. Name and address of person who completed cause of	death (item 23a)	(Type_Print)	Region		1-16	ter Salis	bury mes
	Sta	ite	31. Date filed (Month, Day, Year) 32. Regin	ar's Signature	enintula	Wegler	as Mico	IICAT ("EA	Her 2011	DWY THE
	Regist		SEP 1 8 2007	ion 1	K Span	E .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 State Registra AMEND#29d, perMD, 9/18/07, DPS, MoCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Sept. **Physician** 16, 2007 Lucretta Lee Grayson 5:10 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F 74 229-38-8873 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 44 Bailey Court 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 9 1 ☐ Yes 2 Ho Specify: Specify: Black à 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Ir portant: If item 27 is marked other than '9 any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. College (1-4or 5+) Nursing Homes Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Page <u> Hannah Basil Page</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son 788 Balls Bluff Road N.E., Leesburg, Virginia 20176 Lawrence E. Grayson/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 9-24-2007 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lyles Funeral Service 21. Signature of Funeral Service Licensee P.O. Box 397, Purcellville, Virginia 20134 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 arro Sequentially list conditions, if any leading to impediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cancer death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ ancytopenia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed OSTridium difficile 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No ospital or Attending Physician: 1 hours after death. uneral Director: After this certificat ly filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 17/2007 29b. Signature and title of certifier 29c. License number Motame 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Motanech 1811 Prince Philip Dr #101, Dlney mb 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of		Re	eg. No2 0 0	7	31382
Ī,	Physici	an	1. Decedent's Name (First, Middle, Last Bertha		reenich			Date of Deat Month	Day Y	'ear	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv			4h Cihi Town o	r Location of Death	Septemb	er 15, 2		8:20 ^{p M}
	Examin	er		· ·							
	Funeral	_	Brighton Gardens 5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last birthday)		I Under 24 Hrs.	8. Date of Birth (Month, Day,	1 9	tgor Birthpl	ace (State or Foreign
Link	Director		5//-14-5816	I□M 27K□F	88 Yrs.	Months Days	Hours Min.			Count ashi	ngton, DC
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation	-			10	d. Inside City Limits
	Aaryk f sho ed at	or									1 □ Yes 21 No
	the 128a-notifi	Director	Maryland Monto	gomery	Ken	sington 10f. Zip Code		10	Og. Citizen of Wh	at Count	ry?
	h with		3604 Astoria Lar	ne		·	20895		U	SA	
	deat	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No-	14. Race -		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 1\text{Yes 2 1\text{Yes}} If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☐ No		ricali, etc./	Spec iyh	White, e	ic.
5-0	72 hc natur dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	ı (Give	dent's Usual Occup	during most of work	ina I	16b. Kind of Busi	ness/Ind	ustry
2	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	d)				
	lled w Hygiei ther th		12 17. Father's Name (<i>First, Middle, Last)</i>	1	Ad	ministrat	ive Assis		Federal		ernment
Maryland	intal heed of	Be	Theodore Sinte				_	elen Diad			
Ž	should ind Men s marke umatic	င္	19a. Informant's Name/Relationship (19b. Maili	na Address (Street	and Number or Run			ate Zin	Code)
	and 2 sealth ar		Peter Sintetos/Br								MD 20902
re,	s 1 and of Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ce)		20c. Location - Ci	ty or Tov	vn, State
E	Pages nent of hant of hant: If ite		1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Parklawn		Park Sep	ot. 21,)1 1 1 1		3 3
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Licer	1see	2	2. Name and Addre	ss of Facility Collins	: Funeral	Rockvill L Home T	e, M	aryland —
<u> </u>	10 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		danes	5 Degle	2	500 Unive	rsity Blv	d, W., S	Silver S	prin	g, MD 20901
B			23a. Part1. Enter the lisease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the leath. Do not en e.	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
10	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		enal Failu	re					onest and beat.
	Examiner		1	,	a consequence of):						
		er	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury		Mass Lesion consequence of a	n					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o	an an rial-tr		resulting in death) Last	Due to (or as a	a consequence of):						
68760	rificate be executed g physician and as the burial-transit	ledical		_ d							
8	e as t		IF FEMALE:								
Вох	The law requires that the death cert te has been signed by the attendining 2 should be detached for use	Physician/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 ☐ Fetal death 3	Ectopic pregnancy	/		23d. Date of		y Day Year
0	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death 5L	Other (specify) _					
Δ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death bu	at not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	ute to the	a cause of death?
Records,	quires n sign ald be	Completed by	Pelvic Mass with	Liver Meta	stasis, Fa	ailure to	Thrive	1 □ Ye	es 2∐No 3	☐ Proba	ıbly 4 🔀 Unknown
O O	s bee	lete						24a. Was ar	24b. We	ere autop	sy findings available ipletion of cause of
	The lay	E O						autops perform 1∐ Yes 🕱	ned? dea	or to com ath?]Yes :	
Vita	ictan: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death			1165	2 110
	Physician: r this certifica ral director, p	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 XNursing Ho	me 5 Reside	nce 6 Other	(Specify))
0	ding Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred		
Sio	Attending r death. ector: After by the funer	cation	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division or	i Gift o	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home, farm, st :. <i>(Specify)</i>	reet, factory, office		28f. Location (Sti City or Town	reet and Number , State)	o <i>r Rural</i>	Route Number,
_	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier 1X Certifying Ph	ysician: To the best o	of my knowledge deat	h occurred at the til	me date and place	and due to the ca	auco/c) and man	ar ae et	ated
	e Hospital	Medical		niner: On the basis of and manner sta	examination and/or in	vestigation, in my	ppinion, death occur	red at the time, da	ate and place, an	d due to	the cause(s)
	To the within 2 To the complet	ĕ E	29b. Signature and title of certified	17,1	/	29c. Licens		29	d. Date signed (Month, E	Day, Year)
)	10		1 /hul-1	1/1	- 11	m 17	3335	7 :	Septem S	_ /	7,2007
		1	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,		-		0	_	
			Lee Jonathan Mush	er, M.D.		onsin Ave	nue, Suit	e 1045,	Chevy Cl	nase	MD 20815
	Sta Registr	e	31. Date filed (Month, Day, Year) SEP 1 8 2	007 32. P distra	r's Signature	Cont.					
	ricgisti			A STATE OF	- 14° Kd						

DHMH 17 Rev 1/2001

Woosung Kim	Stat Maryland / Depar	rtment of Health and Me Hygiene ifficate of Death	Reg. No. 2007 3138
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) WOO SUNG KIM	2. Date of E Month Septem	
4	4a. Facility Name (if not institution, give street and number) Maryland General Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Ias 6.72 0.9 23.73 1X M 2 F 4.2	st birthday) If Under 1 Year If Under 24Hrs. 8. Date of Months Days .Hours Min. MARC	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) H 15, 1965 S KOREA
low any	, , ,	Fown or Location NESVILLE	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number 6845 HOLLOW GLEN CT	10f. Zip Code 20155	10g. Citizen of What Country? S KOREA
f (rai", or items 23. inner must be no by Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify:	White, etc. Specify: ASIAN
2 hour "natu	Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPIETOR	16b. Kind of Business/Industry RESTAURANT
21215-0036 21215-0036 Mental Hygiene. marked other than e event, the Media-	17. Father's Name (First, Middle, Last) HEE JOO KIM 19a. Informant's Name/Relationship (Type, Print)	18. Mother's Name (First, Midd ANH JONG 19b. Mailing Address (Street and Number or Rural Route	SANO
MD Id 2 sho If h and If h and an 27 is an mati	HYUN JOO KIM / WIFE 20a. Method of Disposition 20b. Pl		GAINESVILLE VA20155 20c. Location - City or Town, State ALEXANDRIA VA
Baltimore, permit. Pages I at Department of Hee Important: If ite	4 Donation 5 Other Specifye 21. Signature of June 11 Service Livinsee	22. Name and Address of Facility CHARLES	HINDS FUNERAL SERV
Physician /Medical caminer	23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic of Due to (or as a consequence of)	Do not enter the mode of dying, such as cardiac or respiratory cardiovascular disease	MARLBORO MD 20772 arrest, shock, or heart Approximate Interval Between Onset and Death
uuted nd ransit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)		
60, tte be executed hysician and e burial - transit	X UNPENDED X AMENDED , PII, 27, pe #1,23a, PII, 27, pe IF FEMALE: 23c. If yes, outcome of pregn.	erME,C872, 10/11/07 TT	23d. Date of delivery
Records, P.O. Box 68760, The law requires that the death certificate be tean been signed by the attending physicipage 2 should be detached for use as the build completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal death 3 Ectopic pregnancy	Month Day Year
s, P.O. I uires that the uires that the n signed by the detection of the d	Chronic renal disease	55 and 5 and	id tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown /as an 124b. Were autopsy findings available
of Vital Records, Ing Physician: The law require: After this certificate has been signineral director, page 2 should be. n: To Be Completed		a 1 v Y	prior to completion of cause of death? 1 Very 2 No
Vital Visitian: ysician: director o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ I	26.Place of Death (Check only one) ER/Outpatient 3 DOA Other; Nursing Home 5	Residence 6 Other:
C = = - D	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 1 X Natural 5 Pending Investigation 28e. Place of Injury - At hor	1 Yes 2 No	ibe how injury occurred on (Street and Number or Rural Route Number, City
O The Politic	4 Homicide determined (Specify) 29a Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, and due to the	cause(s) and manner as stated.
To the Hos within 24 h To the Fur completely Medical (one) 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	d/or investigation, in my opinion, death occurred at the time, o	late and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	(Carlabelle)	O.C.M.E.	September 25, 2007
CR	30. Name and address of person who completed cause of death (Item Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	
State Registrar		ed .	

DHMH 17 Rev 1/2001 OCME 2006

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 ho

To the Fun

completely

6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death accounted the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier naus mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aue Svite Pennsy Strauss Rell. 13424

15 State

Registrar

Medical

31. Date filed (Month, Day, Year)

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DEALL

State of Maryland / Department of Health and Mental Hygien State Registrer Amend #26 per PHYS/FH 09-1862001/10202000 Death Amend #23b FD Ro. PHYS 09-26-07 CNM 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT. 14 **Physician** 20'67 1:00 PM JEANNE ELIZABETH KING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK 508 KNOXVILLE ROAD KNOXVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | JUNE 10 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number)^{Yea}r) 947 **Funeral** 1□M 2**⊠**F Yrs. 60 219-48-3909 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-f show with jury or other treumatic event, the Madical Examinat must be notified at once. 10b. County 1 ☐ Yes 2 ☑No WV **JEFFERSON** HARPERS FERRY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25425 USA 376 LAMONTE DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? / 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NATIONAL INSTITUTES Elementary/Secondary (0-12) 1 2 College (1-4or 5+) SECRETARY HEALTH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VIOLA ELIZABETH WHISMAN WILLIAM RUSSELL BAKER, SR. ၉ 19a. Informant's Name/Relationship (Type, Print)
VALERIE TURNQUIST/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 KNOXVILLE RD., KNOXVILLE, MD 21758 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MONOCACY CEMETERY 9/18/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Dicenses HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 Immediate Cause (Final MuroCardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mellita 2 No 3 Probably 4 Unknown Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Daughters Other: 4 Nursing Home Statesidence 6 NOther (Specify) House 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tele of certifier 00064568 9-17-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 660 Ninth Grunguli 31. Date filed (Month, Day, Year) State SEP 1 8 2007 Registrar DHMH 17 Rev 1/2001

		,	For State Registrar	tate of Ma	aryland		artment o r <i>tificate</i>			1ental Hy	giene Reg. No	0007	31:	386	
ľ	Physici		1. Decedent's Name (First, Middle, Last) Gertrude Laura Kenne	> V					S	2. Date of De Month eptemb	eath Da	y Year	3. Time of 12:30	Death A M	
	/Medic Examir		4a. Facility Name (If not institution, give street WICOMICO NURSING HO	et and number)			4b. City, Tov				4c. County of Death WICOMICO				
	Funeral Director		5. Social Security Number 6. Sex 1 □ M		e (<i>In yr</i> s. <i>Ia</i>	a <i>st birthday)</i> Yrs.	If Under 1 \ Months D	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Date of Bir (Month, Date 2-11-1	th ay, Year) 932	9. Birt Co De 1	untry)	or Foreigr	
DAILITIOTE, INTELYIGITION ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade co	Heb Ever in U.S	16a. Deced (Give life.) Gant	Was Deceden If Yes, specify 1 Yes 2 dent's Usual C kind of work of DO NOT use r Shirt ag Address (S 4 Ibis	2 to f Hispanic Cuban, Mex No Spectocupation one during relived) Facto 18. M. An: treet and Nu Court	nost of work ry other's Name nie Sa mber or Rur	e (First, Middle avage al Route Numb	USA 16b. K Sean Seen, Maiden per, City or ryla:	14. Race - Ame Black, White Specify: White ind of Business/ mstress a Surname)	1X Yes untry? ncan Indian, e, etc. aite Industry Zip Code)	-		
Dallillore	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee	000		oron Co		ddress of Fa	9-14	-07 inds Fu	Heb nera	ron, Mar 1 Home	ryland		
0000	Physician /Medical Examiner physician and physician and physician and the physician with the physician and physici	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									Interval Bet	tween		
P.O. DOX 00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal t time of de	death 3E	□Ectopic pregi □ Other (speci	fy)	art I.	23e. Did		Month	Day		
a Records,		Completed by	ATRIAL FIBRIC					24a. Was	psy ormed?	290 2007 12:30 A Moreoscopic Country of Death VICOMICO 10. Country of Death VICOMICO 10. State or Foreign Country of Delaware 10. Inside City Limits 1x yes 2 No. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry Amstress In Surname) 10. Country of Death of State or Foreign Country of Town, State, Zip Code of Town, State, Zip Code of Town, State or Town, State					
DIVISION OF VITAR	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes No Host 27. Manner of Death 2 Accident investigation 3 Suicide 6 Could not be determined	28b. Time o Injury	nt 3 DOA f 28c. M eet, factory, o	Other: Injury at Work? 1 Yes 2	Nursing Ho	28d. Describe	idence how inju	ry occurred and Number or Ri		nber,			
בֿ	o the Hospital o vithin 24 hours aft o the Funeral Di ompletely filled in	Medical Cer			f examinat		vestigation, in	my opinion,	death occur er	rred at the time	, date an	d place, and due	e to the cause(s	s)	
	F ₹ F ŏ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOGESH VOLRA, MD 614 EASTERN SHORE DR., SALISBURY, MD 21804									۲,			
	Sta Regist		YOGESH VOLRA, MD 61 31. Date filed (Month, Day, Year) SEP 1 3 2007			HORE D		TZROK	.1, MD	21004					

			For State Registrar		State of Ma	aryland / l	-	rtment of H			P	Reg. No	2007		
	Physici		Decedent's Name (First James	t, Middle, Last) Georg	-	antzes					Date of Dea Month 201.	ath Da <i>O &</i>	y Year 2007	3. Time of De	eath M
	/Medic Examin Funeral Director	er	4a. Eacility Name (If not in the control of the con	getitution, give :	street and number) (Medicol	Cente e (In yrs. last bir 83	rthday) Yrs.	4b. City, Town, or Surface of Sur	bury	Death Hrs. 8.1	Date of Birth Month, Day	4c	County of Dea	ith	
	ryland how at		Usual Residence of Dece 10a. State 10b.	County		10c. City, Tow	n or Lo	cation						10d. Inside City I	
	ne Mar 8a-f st ptiffled	Director	4	Wicomic	:0	Salis	bur					10 - 0	1	1 XYes 2	□No
	with the sa or 2 the not	Dir	10e. Street and Number 751 Richw	ill Dri	ve			10f. Zip Code 21801	1			-	tizen of What C JSA	ountry :	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ □	2 X Married	12. Was Decedent I Armed Forces? 1 XYes 2	No.	13. V	Vas Decedent of H Yes, specify Cuba □ Yes 2 1 No	lispanic Origir an, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)		14. Race - Am Black, Wh		
21215-0036	72 hour 'natural' dica Ex	Completed b	15. C	Decedent's Edu ly highest grad	cation	dr Tiles	. Deced	ent's Usual Occup	during most o	of working		16b. K	and of Business		
121	within ene. than "	duc	Elementary/Secondary	(0-12)	College (1-4or 5	i+)		00 NOT use retired fessor	d)			Uni	versity	of Mary	land
Maryland 2	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Paul Georg				<u> </u>		18. Mother's Katl	,	rst, Middle, Miskov	Maider	Surname)		
lary	2 shou and N is ma rauma		19a. Informant's Name/F			198		g Address (Street						Zip Code)	
nore, N	ages 1 and int of Health t: If item 27 y or other t		Helen L. K 20a. Method of Disposition 1 ☑ Burial 2 □ Cre	n mation 3 □ F	Removal from State	cemete	f Dispo	Richwill Sition (Name of natory or other place Memorial	ce)	Date 9/12/0	Ī	20c. L	ocation - City o		
Baltimore,	permit. P. Departme mportant any Injury 2nce.		4 □ Donation 5 □			Par	rk	Name and Addre		<u> </u>				ssociatio	on
-62			23a. Part1. Enter the dis	ease, or compl	ications that caused ne cause on each lin	the death. Do								Approximate Interval Betwe	en
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	are. Electriny el	a		Si	ibdwal Fall	Herrita	wen				Onset and Dea	u)
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	ted nsit	niner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	ate	Due to (or as	a consequence	of):								
68760,	e be execu sician and e burial-tra	edical Examiner	that initiated events resulting in death) Last		Due to (or as	a consequence	of):								
_	sertificate ding phy se as the		IF FEMALE:		23c. If yes, outcome	of pregnancy							22d Data of d	liver	
P.O. Box	the death or y the attend ched for us	Physician/M	23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nam		2 Fetal death		Ectopic pregnancy Other (specify)	<i>y</i>				23d. Date of de Month	Day Yea	ar
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ò	Part II. Other significant	conditions co	ntributing to death b	ut not resulting i	n the ur	derlying cause giv	en in Part I.	_	23e. Did to		3	to the cause of dea Probably 4 □Unl	
Division or Vital Records,	The law re ate has be page 2 sho	Completed								_	24a. Was a autop perfor 1 Yes		prior to death?		
Vita	s ician : Th certificate rector, pag	Be	25. Was case referred to examiner?		Hospital:	0FFP/0		Oth	or		heck only o		0 TO# (0		
1 Or	ding Physician: The n. After this certificate hi funeral director, page	n: To	1 Yes 2 No 27. Manner of Death		28a. Date of Inju		Time of	28c. Injur	4 □ Nurs			_	6 □Other (Sp iny occurred	ecity)	
sion	tendin eath. tor: Aft the fun	catio	2 Accident	Pending investigation Could not be	9/4/07	5	145	- M 1□	Yes 2 No		Fai		nd Number or I	Rural Route Numbe	
Ο̈́	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Certification:	4 ☐ Homicide	determined	building, et	c. (Specify)	aiiii, sui	eet, factory, office			City or Tou	vn. Staf	will Vir.	Salisby	
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	sician: To the best iner: On the basis o and manner st	f examination a	e, death nd/or in	n occurred at the tile vestigation, in my o	me, date and opinion, death	l place, and h occurred	due to the at the time,	cause(s date ar	s) and manner and place, and di	as stated. ue to the cause(s)	
)	X//	Me	29b. Signature and title	f certifier				29c. Licens	e number)		29d. Da	ate signed (Mor	nth, Day, Year)	
	2 Dr		30. Name and address of	f person who to	ompleted cause of d			Print) Carp	11 5't		Salis	sky	M	v).	
	Sta Registi		31. Date filed (Month, Da			ar's Signature		1							
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07-07380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Laurette S. Lucid 2007 31388 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year September 21, 2007 1006 hrs Medical Examiner Lairette Suzanne Lucid 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown Washington Washington County Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Davs Hours Director Country) 579**-**42**-1**473 M 2 X F 82 Nov. 27. 1924 France Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 Yes 2 X No 28a-f show Franklin 23a or 28a-f sho notified at once. Waynesboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11480 Pine Hill Dr. 17268 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 XMarried 2 X No Yes Specify: White Yes 2 X No specify: it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner Divorced If Yes, Give Year ŝ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed it. Pages 1 and 2 should be filed within 72 hor rement of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie T. Miselone Flie J. Brune1

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Lucid 11480 <u>Pine Hill Dr. Waynesboro, PA 17268</u> husband 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, 1 X Burial 2 Cremation 3 X Removal from State 10/15/2007 Arlington, VA Arlington Nat. Cem. Donation 5 Other Specify: 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licens 50 S. Broad St., Waynesboro, PA 17268 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line 'Medical Death a. Multiple Injuries Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED UNPENDED attending physician or use as the burial -Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) isigned by the atte 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? <u>о</u> contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? 2 No Yes 2 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other₄ examiner? Inpatient 2 V ER/Outpatient 3 1 V Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Driver auto box truck collision Sep 21, 2007 0845 hrs Natural neral Director: / 1 Yes 2 ✔ No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) 14965 Buchanan Trail E., Waynesboro, PA determined (Specify) Major Road Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 23, 2007 30. Name and address of person who completed cause of death (Item 23a) 15

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

Patricia Aronica-Pollak MD.

200

OCME

GOBALL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signatu

		o.m	# 4c per phys., 9/2	•	-	nent of Health and cate of Death		giene 007	31389
an	lend It		1. Decedent's Name (First, Middle, Last)	4/0/ 60	00/1,,,,		2. Date of De	eath	3. Time of Death
	Physici			G T 3110	ON		Month	Day Yee Der 17, 200	7 2.00 DM
~	/Medio		MARGARET 4e Facility Neme (If not institution, give st	G. LAWS	ON	4b. City, Town, o	or Location of Deet	h 4c. County of De	Somerset
1	Examir	er				Crisfie		-USA	Somerset
	8		MCCREADY MEMORIAL F 5. Social Security Number 6. Sex	7. Age (In yrs.	lest hirthday) If U		rs. 8 Date of Bir	th 0.8	Birthplace (State or Foreign Country)
	Funeral		10	M 2137F	Yrs Moi	nths Days Hours Mi	in. (Month, Da	ay, Year)	
	Director	-	218-20-6029 Usuel Residence of Decedent)1		APRIL .	17, 1916 Ma	aryland
	lend Mark		10a. Stete 10b. County	10c. Cit	y, Town or Location	1			10d. Inside City Limits
	Mary	ğ	Manual			Marion Statio	On		1 ☐ Yes 2/XNo
	288 101	Director	Maryland Somerset 10e. Street and Number		10	f. Zip Code	OII	10g. Citizen of What	Country?
	With Se of					27.020		1107	
	ter death with the Marylen Hams 23a or 28a-f ehow ther must be notified at	Funeral	27552 Farm Market I	ROAD 2. Was Decedent Ever in U	S. 13. Was I	21838 Decedent of Hispanic Origin? Specify Cuben, Mexican, Pu	(Specify Yes or No	USA 0- 14. Race - Ar	merican Indian,
_	ter o	F	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☒ No			erto Rican, etc.)	Black, Wi	
ž	irs of	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1□Y	es 2⊠ No Specity:		Specify:	White
ŏ	within 72 hours efter death with the Marylend liene. r than "naturel", or frame 23a or 28a-f ehow the Medical Examiner must be notified at	8	15. Decedent's Educa	ation	16a. Decedent's	Usual Occupetion	4.5-	16b. Kind of Busines	ss/industry
72	in 7	Completed	(Specify only highest grede	completed) College (1-4or 5+)	(Give kind o	of work done during most of w OT use retired)	vorking		
2	with liene.	E	1 2	College (1-40/ 3+)		Manager		Cutlery F	Retail Outlet
b	F Fyg	Be C	17. Father's Name (First, Middle, Last)				lame (First, Middle	, Maiden Sumame)	
lan	0 5 6 0	To B	John Sedlmayer			Bess	Ford		
2	d 2 should by the end Mente 7 is merked traumatic end		19e. Informent's Name/Relationship (Typ	e, Print)	19b. Mailing Ad	dress (Street and Number or	Rurel Route Numb	er, City or Town, State	a, Zip Code)
ž	od 2 Ithe 27 is				27552	Farm Market Ro	oad – Mar	cion Static	on, MD 21838
ē,	is 1 and 2 of Health e item 27 is other train	ı	Leslie Wilson (Gran 20a. Method of Disposition	rcdaughter) 20b. F	Place of Disposition	(Name of	Date	20c. Location - City	or Town, State
2	nt of		1 Burial 2 Cremation 3 Re	emoval from State	emetery, cremator		0 (20 (0)	Conic field	Marelland
Baltimore, Maryland 21215-0020	permit. Peges I Depertment of H important: if ite any injury or of pace.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	4.7	ury Ceme	Tery ne and Address of Facility	9/20/0	Crisfield,	Maryland
Ba	Depermonent of the popular in the po		May BT +	Bloke		DSHAW & SONS	FUNERAL F	HOME	
	40244		Mary Seth Brad	shaw-Pruitt	306	W. Main Stree	et - Cris	sfield, MD	
4.10			23a. Part 1. Enter the diseese, or complic shock, or heart failure. List only one	ations that caused the deat a cause on each line.	h. Do not enter the	mode of dying, such as card	liac or respiratory a	arrest,	Approximate Interval Between
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1000	/Medical		tmmediate Cause (Final disease or condition		ASCI	D			1
	Examiner		resulting in death)	Due to (c	or as a consequenc	e of):			
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	nd rens	am	Sequentially tist conditions,	Due to (c	or as a consequenc	e of):			
Ó,	the death certificate be executed by the attending physician end sched for use as the buriel-trensit	Ñ	if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury						
8760,	ysic he bi	edical	that initiated events resulting in death) Last	Due to (c	r as e consequence	e of):			
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Box	h cel	Sugar.	d.						
Ξ.	v requires thet the death certific been signed by the attending p should be deteched for use es	Physician/M	Part II. Other significant conditions conti	ributing to death but not res	ulting in the underly	ring cause given in Part I.	23b. Did	tobacco use contribu	ute to the cause of death?
P.O.	by th	h	PA	IEU MONIA			1	Yes 2XNo 3	Probably 4 Unknown
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of Vital Records,	The law requires thet ste hes been signed b pege 2 should be dete	8					24a. Was	s an autopsy 24 ormed?	Were autopsy findings available prior to
္ပ	A rec	let					-	ominos.	completion of cause of death?
æ	The law ete hes pege 2	Completed					407	Yas 2XNo	1 ☐ Yes 2 ☐ No
ā			25. Was case referred to medical			26 Place of F	Death (Check only		
⋚	Physician: this certific ral director,	o Be	examiner?	ospital: محتددات	ER/Outpatient 3	Other		idence 6 □Other (S	'necifu)
ō	Phys this rai di	- P	1 Yes 25 No	28e. Date of Injury	28b. Time of			how injury occurred	pecny)
L C	ling After fune	Ö	1)XNatural 5 ☐ Pending	(Month, Dey Year)	Injury N	28c. Injury at Work? I 1 ☐ Yes 2 ☐ No			
Division	Attanding or death. actor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome farm street f		28f. Location	(Street and Number or	Rural Route Number,
Ξ	or Al	늹	4 ☐ Homicide determined	building, etc. (Specif	ý)	actory, cines	City or To	wn, State)	
الت	To the Hospital or Attanding F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		20a Cartifier + All Cartifier Phone	plen. To the heat of my to	wledge death acco	urred at the time, date and pla	ace, and due to the	cause(s) and manner	as steted.
	Hospital 24 hours Funeral stely filled	edical	(Check only 2 Medical Examine	er: On the basis of examina	ition and/or investig	ation, in my opinion, death or	ccurred at the time	, date and place, and	due to the cause(s)
	To the within 2 To the Complet	Med	one)	and manner stated.		29c. License number	T	29d. Date signed (Mo	onth, Day, Yeer)
	o vit	-	29b. Signature and title of certifier	1 10		D 4809	2		12007
				1		V 450 TR	>	-1111	1200
			30. Name end address of person who con						
			Vijay Karumbuna	athan, M.D	- 201 Hal	1 Highway - C	risfield.	MD 21817	
\$	Sta		31. Date fited (Month, Day, Year)	32. Registrar's Signa	ature M.	aste)			
	Registi	ar.	SEP 1 8 2	ON SUPPLIES	20 M				

DHMH 16 Rev 6/95

			For State of State of Registrar	Maryland / Depa	artment e rtificate			nd Mental H			0.1.0.0.0
ķ			Decedent's Name (First, Middle, Last)			0, 0		2. Date of D			3. Time or Death
	Physici /Medi		Alfred Joseph Litwin					Septem	ber .	14, 2007	5:05 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number Maplewood Park Place	per)	4b. City, To Bethe		ocation of	Death		County of Death	N7
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1	Year	If Under 24		irth		place (State or Foreign ntry)
	Director		046-12-2336	83 Yrs.	Months [Days	Hours	Min. (Month, D	ay, Year) 1924	4 New	York
/land	at ow		10a. State 10b. County	10c. City, Town or Lo	cation			<u> </u>			0d. Inside City Limits
e Man	a-f sh liffed	ctor	MD Montgomery	Bethesda							1 □ Yes 2 No
vith th	or 28 be no	Director	10e. Street and Number		10f. Zip Co				10g. Citi	izen of What Cour	ntry?
eath	ns 23a must	eral	9707 Old Georgetown Road 11. Marital Status 12. Was Deced		2081		ania Oriala	-2 (Cit: VN	USA	14 Dans America	on Indian
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 Married	□ No	was Deceder If Yes, specify 1 ☐ Yes 2 ☐			n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	etc.
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	Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	Busine	ess Own	$\overline{}$	8. Mother's	Name (First, Middle		tiques Surname)	
aryland 2:	fental rked o tic eve	To Be	Louis Litwin					Belin	, marder	<i>Surname</i>)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af	alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print) Evelyn Litwin/Wife	19b. Mailir 9707	g Address (S	itreet and	d Number o	or Rural Route Numi	oer, City o	r Town, State, Zip thesda, N	Code) 4D 20814
Imore, Pages 1 a	or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from St	20b. Place of Dispo cemetery, crer	natory or othe	er place)		Date		ecation - City or To	
iltir	artmer ortant injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee	Chesapeal						tsville,	
Balt permit.	any any onc		Beuch & Ho. A.					tion Serv			x 784 e. MD 21029
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode o	of dying,	such as ca	rdiac or respiratory	arrest,	11 KSVIII E	Approximate Interval Between
	ysician Medical		resulting in death)	ction of Tho	asic A	Aorta	а				Onset and Death
No.	aminer		Due to (or	as a consequence of):							
T		ner	Sequentially list conditions, if any, leading to immediate cause. Liner Uniderlying Cause (Disease or injury	as a consequence of):							
ecute	and -transi	Examiner	reculting in death) Leet								
ate be ex	physician and the burial-transit	dical E	d d	as a consequence of);							
C 58	ng phy as th	Medi	IF FEMALE:								
ords, P.O. BOX 68/60, requires that the death certificate be executed	the attending phed for use as t	Physician/Me	23b. Was decedent pregnant 1□Live birt	h 2 ☐ Fetal death 3 ☐ It at time of death 5 ☐	Ectopic pregr Other (special				2	23d. Date of delive Month	ry Day Year
that t	ed by		Part II. Other significant conditions contributing to deal	h but not resulting in the ur	derlying caus	e given i	in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
cords v requires	keen signed by the should be detached	ted by						1	Yes 2X	No 3□ Prob	ably 4 □Unknown
<u>a</u>	has e 2	Completed							psy ormed?	prior to cor death?	osy findings available npletion of cause of
VII.	ertifica ector, I	Bec	25. Was case referred to medical examiner?				6. Place of	Death (Check only	2□No one)	I I I I I I I I I I I I I I I I I I I	2 X No
Physi	this o	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp 27. Manner of Death 28a. Date of			Other:		ng Home 5□Res)
	ur. ; After	tlon		Day Year) Injury	M 28C.	Injury at Work? 1 ☐ Yes	t s 2⊡No	28d. Describe	how injury	y occurred	
l or Attending Physician:	Director Director I in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of	injury - At home, farm, stre etc. <i>(Specify)</i>	et, factory, of	ffice		28f. Location (City or To		d Number or Rura)	l Route Number,
To the Hospital	within 24 nous arter beaut. To the Funeral Director. After this certificate to completely filled in by the funeral director, p.g.	edical C	29a. Certifier (Check only one) 1 \(\) Certifying Physician: To the basi and manner	s of examination and/or inv	occurred at t estigation, in	he time, my opin	date and p lion, death	place, and due to the occurred at the time.	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
To th	To th		29b. Signature and title of certifier	1 MD	29c. Li	cense nu	umber		29d. Date	e signed (Month, i	Day, Year)
			1/1/er Cyn V	emung		3579	1		09/1	.4/07	-,1,1
54)0	d l	1		801 Georgia		227	Silv	er Spring	, MD	20902	997 January 194
*	Stat Registra			strar's Signature	est!						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Month Year 2007

Day

4:54

September 11,

Baltimore, Maryland 21215-0036 Beatimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Sysician and any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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Van Lenten

Exami	ner	4a. Facility Name (If not insti	ve street and nu		4b. City, Town, or Location of Death 4c. County of De						th				
		Suburban Ho	spit	:al				Bethesda					Montgomery		
Funeral		5. Social Security Number		Sex	7. Age (In	yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 H		irth	9 Birthplace (State or Foreign			
Director		148-28-3811		1⊠M 2□F		69	Yrs.	Wioritiis Days	Hours Wil	Aug. 2				w Jersey	
and *		Usual Residence of Deceder 10a. State 10b. Co			100	. City, Tow	n or Los	notion						1	
laryla shor	5		,		100.									10d. Inside City Limits 1X Yes 2 □ No	
he M 28a-f otifie	Director		ntgo	mery		Rock	vil]								
with t		10e. Street and Number						10f. Zip Code			10g. Ci	tizen of	What Co	ountry?	
s 23s	rai	1105 Cedrus	Way						854					tates	
item item ner n	Funeral	11. Marital Status	Mandad	12. Was Dec	orces?	n U.S.	13. V	as Decedent of i Yes, specify Cub	Hispanic Origin? Dan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-		ce - Ame ck, White	erican Indian, ce, etc.	
rs aff	by F	1 ☐ Never Married 2🔯 3 ☐ Widowed 4 ☐ Divo		If Yes, Gi	2□No ive Dates1967	7 05	1	☐ Yes 2፟█ No	Specify:			Specif	y: ~		
tura attura	ed				201907		Deced	ent's Usual Occu	nation		16h K	ind of D		aucasian	
be filed within 72 hours after death with the Maryland tall Hygiene. td other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Scientist Administrator										ublic Health				
d with	E	Elementary/Secondary (o-	2)	5+	1-401 5+)	Med	ica	1 Scient	ist Adm	inistrat			ervi		
othe	Bec	17. Father's Name (First, Mic	dle, Last	t)					T	ame (First, Middle					
ald but Aenta	Louis Sutton Van Lenten Jane T. Vanden Berg														
shol		19a. Informant's Name/Rela	ionship ((Type. Print)		19b	. Mailing	Address (Street		Rural Route Num			State, 2	Zip Code)	
and 2 alth a	Elizabeth J. Van Lenten / Wife 1105 Cedrus Way, Rockville, Maryland									and	2081	54			
oth oth	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)								T			Town, State			
D of it	1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 9/18/2007 Ale								Ales	zand:	ria	VΔ			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Simple Tribute Funeral and Cremation										VA.			
permi Depa impo any is		1040 Rockville Pike, Rockvill										emat • M	10n (284)	Center	
		23a. Part1. Enter the diseas sho x, heart failure.	o com	plications that o	caused the d	leath. Do r	ot ente	r the mode of dyi	ng, such as cardi	ac or respiratory	arrest,	, II	ary	Approximate	
Physician		Immediate Cause (Final	Lagar Office	one cause in e				(051)						Interval Between Onset and Death	
/Medical		disease or condition resulting in death)		a. Due to	(or as a cons	_		10717					-		
Examiner				A	Nov-i	VIAG	1	longly					- 1		
EXTENSE.	Jer	if any, leading to immediate cause. Enter Underlying	•	b. Due to	(or as a cons	sequence o	100	1011111							
cutec nd ransii	Examiner	Cause (Disease or injury that initiated events	1	C.				,							
that the death certificate be executed of by the attending physician and detached for use as the burial-transit		resulting in death) Last		Due to	(or as a cons	sequence o	of):								
ate b hysic the bu	ica			_d											
ertifica ing pl	Physician/Medical	IF FEMALE:		-						_					
eath cer attendin for use	an/	23b. Was decedent pregnan in the past 12 months?	T _C	23c. If yes, out 1☐Live b	tcome pf pre pirth 2 F	gnancy etal death	3□8	Ectopic pregnanc	v				te of deli		
at the dea by the a tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	İ	4□Pregr 9□Unkno	nant at time o	of death		Other (specify)	,			Мо	nth	Day Year	
that the	Phy		dialone												
	by	Part II. Other significant con	uitions c	contributing to de	eath but not I	resulting in	tne uno	lerlying cause giv	en in Part I.					the cause of death?	
w requires to been signed should be considered.	ted									1	Yes 2	□ No	3 ☐ Pro	obably 4 🗗 Unknown	
The law requires are has been sign bage 2 should be	Completed									24a. Was	an Insv	24b. \	Nere au	topsy findings available completion of cause of	
	9	death? performed? death?													
iclan: Th certificate ector, pag	Be	25. Was case referred to me examiner?	lical						26. Place of De	eath (Check only					
hysi this c	၉	1 ☐ Yes 2 ☐ No				ER/Out	patient	3□ DOA Oth	er: 4 Dursing	Home 5□Res	idence	6 □Oth	er (Spec	cify)	
fter i	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pe	nding	28a. Date (Mont	of Injury th, Day Year,	28b. T	ime of ijury	28c. Injur Wor	y at k?	28d. Describe	how injur	y occurr	ed		
tend eath. tor: /	cati	E C / NOOIGOIN	estigation ald not be						Yes 2 ☐ No						
or At fter d Direct in by	27. Manner of Death 1 2 Natural 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										er or Ru	ral Route Number,			
pital		200 Cortifier	fuller - Dr	unatalo - 7 ::	h *		4. 0		77.						
Hos 24 ho Fun	ica	29a. Certifier 1 Certifier (Check only one) 2 Med	rying Ph cal Exan	niner: On the ba	asis of exam	knowledge, ination and	death of dea	occurred at the tilesting	ne, date and plac pinion, death occ	e, and due to the curred at the time	cause(s) , date and	and ma	nner as and due	stated. to the cause(s)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	29b. Signature and the grade		and manr	ner stated.			29c. Licens							
F 3 F 8		I									∠yu. Dat	signed	(IVIONIN	n, Day, Year)	
15	-	about .							161302		4	116	04		
ソー		30. Name and address of per Atul Rohatgi		completed caus					1	36		\	(
Sta	10	31. Date filed (Month Say, Y	ar) _	32. R	Strar's Sig	nature	r Dr	ive, Ko	ckville,	Marylar	nd 20	850			
- Sta		SEP	18	2007	80.0	de	A								

		•	For State of Mary 1 - State Registrar	riand / Depa <i>Cer</i>	nπment of Η <i>rtificate of L</i>	eaith and M Death	ientai Hygi Re	ene g. No. 2007	31392
P	-36	נר	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Enrico Lovisa				Septembe	r 15, 200	7 4:00 PM
	Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dear	th
1	× 1 8 000		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Silve:	Spring If Under 24 Hrs.	8. Date of Birth		nomery thplace (State or Foreign
	Funeral Director		1 ₩ 2 □ F	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co	ountry)
Н			579-64-7589 Usual Residence of Decedent	61			UCT. 28,		nington, DC
	ryland how		10a. State 10b. County 10	c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ne Ma 8a-f s	ҫ	Maryland Montgomery	Silv	er Spring	J		O'M's and Calledon Co	
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code 20902		110	g. Citizen of What Co USA	ountry :
	eath v	eral	901 Arcola Avenue 11. Marital Status 12. Was Decedent Even	r in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
-0030	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Fun	Armed Forces? 1 ★ Never Married 2 Married 3 ★ Widowed 4 Divorced Armed Forces? 1 ★ S 2 ★ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🙀 No		Rican, etc.)	Black, Whit	
2	רסל 72 hou "natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of OO NOT use retired	luring most of work		16b. Kind of Business	/Industry
7 7	withir ene. than he M	ᇤ	Elementary/Secondary (0-12) College (1-4or 5+)		er Worked			N/A	
0	illed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)	1.000		18. Mother's Name	e (First, Middle, M	faiden Surname)	
yland	uld be Jenta rked tlc ev	To B	Orlando Lovisa			I	da Fratt	a	
Mary	nd 2 shou lith and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print) Teresa Barnard/Aunt		3			City or Town, State,	
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 → Burial 2 □ Cremation 3 □ Removal from State		sition (Name of matory or other place et Cemete	Sept.	19	20c. Location - City or Vashington	
Бантто	permit. I Departm Importar any Inju		21. Signature of Funeral Service Licensee	Fr	Name and Address cancis J.	Collins	Funeral	Home Inc	g, MD 20901
			23a, Part1, Enter the disease, or complications that caused the						Approximate Interval Between
١,	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Cardiopu	lmonaru	Arrest				Onset and Death
£.	/Medical		resulting in death) Due to (or as a co		Allest				
	Examiner		Sequentially list conditions. Shock b.						
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Bilatera	onsequence of): 1 Pneumor	nia				
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g/00	be es	ᇤ							
2	ficate p phys	edical	d						
C. BOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of de Month	olivery Day Year
7.	that t ed by detac		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute t	o the cause of death?
dS	requires that een signed b nould be deta	d by	Sepsis				1 □ Y€	es 2□No 3□P	robabły 4 🛮 Unknown
Kecord	e la has je 2	Completed					24a. Was an autops	y prior to ned? death?	
g	iclan: Th certificate rector, pag	a)	25. Was case referred to medical			26. Place of Deat		2 🔯 No	S 2 NO
2	S S ≔	OB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1★ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Reside	ence 6 □Other (Spe	ecify)
on or	ding Phi th. : After thi funeral	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Worl	y at ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVISION	al or Attending F safter death. I Director: After d in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (5	- At home, farm, str Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the	Medical C	29a. Certifler (Check only one) Check only one Check on	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	and due to the corred at the time, d	ause(s) and manner a ate and place, and du	s stated. le to the cause(s)
		Me	29b. Signature and title of certifier	9d. Date signed (Mon					
)	2			L (II 00-) (T	Drint	D64100		September	16, 2007
			30. Name and address of person who completed cause of death Smitha Bhikkaji, M.D.	1500	Forest G	len Road,	Silver	Spring, M	D 20910
	Sta Registi		31. Date filed (Month Pay Year) 2007 32 egistrar's	Signature	nerth				

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		artment of H rtificate of L		nd Mental H	ygien Reg. N	7111	7	31	393
		k	1. Decedent's Name (First, Middle, La	st)					2. Date of Month		ay	Year	3. Time of	of Death
	Physici /Medio		William Le	WIS				09	13	3 20	207	9:15	AM	
Y	Examin	er	4a. Facility Name (If not institution, giv	e street and number) BAYNEW	me	ucal	4b. City, Town, or	Himmi	Death Ver	4	c. County o	f Death		
			5. Social Security Number 6.5		e (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of I	3irth .		9. Birthp	lace (State	or Foreign
	Funeral Director			M 2□F	15	Yrs.	Months Days	Hours I	Min. (Month, Aug.	Day, Yea		Couir	_{otry)} brida	e
10	pu ,		Usual Residence of Decedent		10c City	Town or Lo	cation					1	Od. Inside (City Limits
	laryla shov	'n	10a. State 10b. County MD Dorche	ator	Toc. Oity,	TOWITOTEC		.l	_					s 2X No
5	the N 28a-f notifie	rect	10e. Street and Number	ster			10f. Zip Code	bridge	3	10g. C	Citizen of W	hat Cour	ntry?	
2	3a or	Funeral Director	6033 Corners Wha	rf Road				21613	3		US	A		
0	death	nera	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin	n? (Specify Yes or	No-		- Americ	an Indian,	
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married	1 Yes 2 □ N	No		1 □ Yes 2 √ No	Specify:	dorto i libari, oto.,		Specify:		ite	
21215-0036	tural'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:1	951-5		16b.	Kind of Bus	iness/In	dustry				
215	hin 72 3. In "na Medio	Completed	(Specify only highest gra Elementary/Secondary (0-12)		i+)	(Give life.	kind of work done of DO NOT use retired	luring most of)	f working					
212	d with	Com	12	College (1 401 o	"		farmer							
pu	be filed tal Hygid d other event, the	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname))		
yla	2 should be f and Mental I is marked of raumatic eve	To	John V. Lewis			405 11-10	4-1 (044		ni Philli		T	14-4- 7i-	Codel	
Maryland	nd 2 sh alth and 27 is n		19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S									
	# # # # # # # # # # # # # # # # # # #		Charlotte Lewis 20a. Method of Disposition	wife	20b. Pla	ce of Dispo	sition (Name of	i	Road, Ca	mbri 20c.	dge, I Location - 0	Oity or To		
MO	0 0		1 ☐ Burial 2XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				matorý or other plac y Cremato		/17/07	Sa	alisbu	ıry,	MD	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice		1 - 4-	2	2. Name and Addres	s of Facility		unera	al Hor	ne P		
			23a. Part1. Enter the disease, or com	pplications that caused	I the death.						210	13	Approxima	ate
ı	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each iir	ne.		al H						Onset and	Death
D. C.	/Medical		disease or condition resulting in death)	a. Due to (or as			act in						27 11	UKKS
	Examiner		Sequentially list conditions	b										
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):								
		Examin	that initiated events resulting in death) Last			Onset and Death								
8760,	sician buria	alE												
9	ificate g physas the	edical		0.						ambridge, MD 21613 20c. Location - City or Town, State Salisbury, MD Funeral Home P.A. ge, MD 21613 Property arrest, Approximate Interval Between Onset and Death Onset Ons				
Box	leath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic pregnancy						-	Vees
	e deal the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)			-	Mon	tn	Day	Year
P.0	hat the de od by the detached		Part II. Other significant conditions	contributing to death be	ut not result	ing in the u	nderlying cause give	en in Part I.	23e. Di	d tobacco	use contri	bute to t	he cause of	death?
Vital Records,	uires tha signed l id be det	d by							1	Yes	2 □ No	3 ☐ Prol	pably 4	Unknown
COL	w require been sign	Completed							24a. W	as an	24b. W	ere auto	psy finding	s available
Re	The lay	omp								rformed?	, q	eath?		cause of
ita		a	25. Was case referred to medical					26. Place of	f Death (Check on	_/	10			
or V	is is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 □ E	R/Outpatier		4 LI Nursi	ing Home 5□R	esidence	6 □Othe	r (Speci	fy)	
n o	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day		28b. Time o Injury	Work		28d. Describ	e how in	jury occurre	d		
sio	ttend death. stor: /	cati	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Place of inju	ury - At hor	ne farm sti	M 1 ☐ `reet, factory, office	Yes 2 No	28f. Location	(Street	and Numbe	r or Run	al Boute No	mher.
Division	I or Attend after death Director:	Certification:	4 ☐ Hornicide determined	building, et	c. (Specify)	,,	201, 143101), 51110		City or	Town, Sta	ate)	,,		,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		nysician: To the best miner: On the basis o and manner sta	f examination									e(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and the state of t			29c. License	number		29d. D	Date signed	(Month,	Day, Year)	
	->-0		Res-000 Sept 13, 200									7		
			30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print)	141 - 0	0000		1			
			Dr. Karen t	nrsch	494	0 Eas	stekn the	nue	DUNIN	ure,1	uv	21	224	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Re	ars signati	R	Book							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV. KAVEN HYSM 4940 EASTERN AVENUE State Registrar 31. Date filed (Month, Day, Year) Registrar														

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who

OCT 0 1 2007

31. Date filed (Month) Day, Year)

null

Street-Hagevernun MD 21740

mpleted cause death (Item 23a) (Type, Print)

32. Registrar's Signature

368

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20071- State MEND#5, 160, 20a, b, c, 21, 22, perFH, 9/18/00 entitle of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Mryczko Sybelle 1200 M SEP 8 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner montsomery Rockville Partnas College If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 27 F 220-60-0749 Alabama 55 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 20850 USA items 23a 548 College Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white ð 3 ☐ Widowed 4 ☐ Divorced **'77-81** "neturel", Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Computer computer programmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be Ethel Virginia Snee Michael Myron Mryczko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1700 Rockville Pike Suite 400 Rockville, MD 20850 permit. Pages 1 and 2:
Depertment of Health at
Important; if item 27 is
eny injury or other trau Theresa Bourbon/executor 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State in state Metropolitan Crematory 9/14/2007 Alexandria, VA 4 □ Donation 5 1 Other (Specify) 21. Signature of Funeral Service Licensee

Note: The first of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 2001

State Anatomy Board 655 W. Baltimore Street

Francis J. Collins Funeral Home, Baltimore, MD 21201 Inc., 500 University Approximate Interval Baltimore Street

Approximate Interval Baltimore Street Interval Baltimor Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if arry, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours efter To the Funerei Dire To the Hospital t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ene) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) well ocal D00438 \sim 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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Year)

8 2007

31. Date filed (Month, Day, You SEP

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32. Restrar's Signature

			For State Registrar	State	of Marylan		artment of F rtificate of		l Mental Hy		2007	31	396	
	Physici		Decedent's Name (First, Middle, L Song Mao	ast)					2. Date of D Month	eath Day	/ Year	3. Time o		
	/Medio Examir		4a. Facility Name (If not institution, g		·		4b. City, Town, c		Sept.		County of Death			
7	Funeral Director		18411 Crownsgat 5. Social Security Number 6. 642-52-8451	Sex 1 M 2 F	7. Age (In yrs. :	last birthday) Yrs.	German If Under 1 Year Months Days		n. (Month, D	ay, Year)	9. Birth	place (State intry)	or Foreign	
la-	aryland show d at	_	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo			TOGITS I			10d. Inside C	ity Limits	
	vith the Ma or 28a-f	Director	Maryland Montgo 10e. Street and Number			Germa	10f. Zip Code 208	7.4		10g. Citi	zen of What Cou		2L X (NO	
336	be filed within 72 hours after death with the Maryland that Hyglene. Ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	18411 Crownsga 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec	edent Ever in U. orces? 2 1 No ve	'		lispanic Origin?	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ameri Black, White Specify: As i	etc.		
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (-	(Give life. L	lent's Usual Occup kind of work done OO NOT use retire ff Scien	during most of w d)	vorking	Ť	nd of Business/Ir	ndustry		
land 2	9 E 5 8	To Be Co	17. Father's Name (First, Middle, La. Hengchang Mao	5+		500	22 00201	18. Mother's N	ame (First, Middle un Du	J., Maiden	Surname)			
Maryland Maryland	es 1 and 2 should bof Health and Ment fitem 27 Is marked rother traumatic e		19a. Informant's Name/Relationship Wei Lu/Wife	(Type. Print)			,		Rural Route Numi	. ,	,	/		
Baltimore,	Pages 1 ament of He ant: If item ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	_	State	emetery, cren	sition (Name of natory or other pla Cemeter	v	Date 15,		ermantow		yland	
Ball	permit. Page Department Important: II any Injury or		21. Signature of Funeral Service Lic	Jedan	V	50	0 Univer	sity Bl	s Funera vd, W, S	ilver				
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Seve	re Bone	Marro	er the mode of dyi		iac or respiratory	arrest,		Approxima Interval Be Onset and 1 Mont	Death	
	Examiner	er	Sequentially list conditions, list yet the cause. Enter Underlying Cause (Disease or Injury	b. Mult	(or as a consequence of the cons	eloma				1 Years				
8/60,	cate be executed physician and the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	uence of):								
O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	tcome pf pregna birth 2 □ Feta nant at time of de own	Ideath 3	Ectopic pregnanc Other (specify)	у			23d. Date of deliv	very Day	Year	
ds, r.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the ur	derlying cause giv	ren in Part I.			se contribute to			
al Kecord	The lar ate has page 2	Completed							24a. Was auto perf 1∐ Yes	psy ormed?	death?	impletion of o	available cause of	
VItal	Physician: this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2□	ER/Outpatien	3 DOA Oth	er.	eath <i>(Check only</i> Home 5 ½ Res		€ □Other (Spec	:6.1		
lon or	ding I. After funer	- 1	27. Manner of Death 1 🔀 Natural 2 Accident 5 Pending investigati	28a. Date (Mor		28b. Time of Injury	28c. Inju		28d. Describe			19)		
DIVISION	irec irec	Certification:	3 Suicide 6 Could not 4 Homicide determine	a Zoe. Place	of injury - At ho ing, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location City or To	(Street an own, State	d Number or Rui)	al Route Nur	nber,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)	aminer: On the b	e best of my kno easis of examina ner stated.	wledge, death tion and/or inv	occurred at the ti restigation, in my	me, date and pla opinion, death oc	ace, and due to the ocurred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s)	
1	To the within complete complet	Me	29b. Signature and title of certifier	0			29c. Licens				te signed (Month		007	
	1		30. Name and address of person wh Ivan M. Borrell	o, M.D	1650 Or	leans	Street,		re, MD 2	1231				
	Sta Registr		31. Date filed (Month SEP 1 8	2007 32. 1	strar's Signa	ture #	have ,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year hekla Nelson 7. 7:30 P M 04 10 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Wicomico Salisbur 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Min. 69 216-70-1800 Director 10/1/1937 Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f show LExaminer must be notified at 1 ☐ Yes 2 X No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 Old Ocean city Rd. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ white 3 Widowed 4 Divorced 'natural', Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hans Schreier (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Addison L. Nelson Jr/husband 3201 Old Ocean city Rd., Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 9/12/07 Salisbury, MD 21. Signature of Funeral Service Liger 22 NoTloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any ir Hall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse u nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) P.0. ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by sign I be should 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page ; certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Coartel HOS 31. Date filed (Month, Day, Year, 82. Registrar's Signature State 1 3 2007 SEP Registrar

Be Certification:

signed by the attending physician and be detached for use as the burial - transi this certificate has been a d director, page 2 should After this certification funeral director, To the Funeral Director: completely filled in by the

27. Manner of Death

Suicide

Homicide 29a. Certifier 1

29 Signature and title of certifier

Pending

Investigation

Could not be

determined

1 Natural

2 🗸 Accident

3

Sa

State Registrar

Records, P.O.

of Vital

Division

events resulting in death) Last	Due to (or as a consequence of):		· ·
UNPENDED	aAMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part t.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medical	26.Place of Death (Check on	y one)	
examiner?	Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other	Home 5 Res	sidence 6 Other:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

Yes 2 V No

28d. Describe how injury occurred

objects

Driver of moped impact with fixed

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State) 5743 Rhodesdale Eldarado Road, Rhodesdale, MD

September 8, 2007

28b. Time of Injury

2008 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

ORIGINAL

2130 hrs

10d. Inside City Limits

Approximate Interval

Between Onset and Death

Yes 2 X No

30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28a. Date of Injury (Month Day Year) Sep 7, 2007

and manner stated

(Specify) Local Street

		For State Registrar	Pleas	State of M		nd / Dep	idelible Ink eartment of F ertificate of	Health	and Me	ental Hyg		egible.	31399
Physicia /Medica		1. Decedent's Nam	, ,	,					2	2. Date of Dea Month	th Day	Year 2007	3. Time of Death 1641 P M
Examine		ANNE ARUN	DEL MED	give street and number	2		4b. City, Town, c	ıs	n of Death		4c. Cou	unty of Death	DEL
Funeral Director		5. Social Security N 218-05-50 Usual Residence of	080	6. Sex 7. A 1 M 2	ge (<i>In yr</i> s. 87	/ast birthday Yrs.) If Under 1 Year Months Days	Hours	Min.	B. Date of Birth (Month, Day JULY 13	, Year)	Cou	place (State or Foreign intry) TLAND
aryland show	'n	10a. State	10b. County			ty, Town or L							10d. Inside City Limits 1 ☐ Yes 2 No
the M	Director	MARYLAND 10e. Street and Nur		ANNE'S	STE	VENSV1	LLE 10f. Zip Code				Ina Citizen	of What Cou	
h with		800 DIXON					21666				J	STAT	•
	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		12. Was Decedent Armed Forces 1 Tes, Give Year or Dates:	?	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic O	an, Puerto Ri	ify Yes or No.	14.	Race - Ameri Black, White	ican Indian, , etc.
72 houndaring	eted	(Snec	15. Decedent			16a. Dece	edent's Usual Occup	pation	not of working		16b. Kind o	of Business/Ir	ndustry
ed within ygiene.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)		e kind of work done DO NOT use retire MAKER					HOME	
l be filk	Be	17. Father's Name		ast)					-	First, Middle,		name)	
should nd Me mark matic	ြ	JAMES JO		p (Type. Print)		19b. Mail	ing Address (Street			SZEWSKI Route Numbe		wn. State. Zi	o Code)
and 2 salth a 1 27 Is er trau		WOODROW	PURCELL	, SR/HUSBAN	D		DIXON DRI						
ges 1 t of He If item or oth		20a. Method of Disp		3 □Removal from State	20b. F	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Dar SEPTEMB		20c. Locati	on - City or T	own, State
iit. Pa urtmen ortant: njury		4 ☐ Donation 21. Signature of ₽	5 Other (Sp		HUR		RYLAND VETS 2. Name and Addre		200	7	HURLO	CK, MA	RYLAND
Deps Impo any i			121e		७८४	(6 E	ELLOWS, H 06 SHAMRO	ELFEN	NBEIN A				HOME, P.A
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b. Cram regarding 5.05%											Approximate Interval Between Onset and Death
bur icia	a Ex	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions, nmediate rlying injury s Last	b. Due to (or as	C	los	opsies	•					
The law requires that the death certificate late has been signed by the attending physicage 2 should be detached for use as the to a specific the lates and the total should be detached for use as the total should be detached for use as the total should be detached for use as the total should be detached for use as the total should be detached for the should be detached	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 9 ☐ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у			23d.	Date of deliv	rery Day Year
w requires that the d been signed by the should be detached	≥	Part II. Other signif	ficant condition	s contributing to death I	out not resi	ulting in the u	ınderlying cause giv	en in Part	1.	23e. Did to			the cause of death?
law req	Completed	Bro	ast o	Concor	,					24a. Was a		4b. Were auto	opsy findings available ompletion of cause of
ician: The law certificate has ector, page 2		Dec	sefe	s Mel	lite	is	·			perfor 1□ Yes	ped?	death?	2 □ No
ysician: s certific director,	o Re	25. Was case reference examiner? 1 ☐ Yes 12 ☐		Hospital: Inpati	ent 2∏	ER/Outpatie	nt 3□ DOA Oth	er.		Check only on		Other (Speci	(6.1)
	7. Manner of Death Accident Spending Suicide Homicide See Place of injury - At home, farm, street, factory, office See Flace See Flace Set Noursing Home See Residence S												
tal or Atter rs after de ral Directe ed in by the	Certific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ed 28e. Place of in building, e	tc. (Specify	y)	reet, factory, office			City or Tow	n, State)		al Route Number,
the Hospi in 24 hou the Funer	Medical	29a. Certifier (Check only one)	Certifying 2☐ Medical E	Physician: To the best xaminer: On the basis of and manner st	of examina	wledge, deat tion and/or in	th occurred at the til nvestigation, in my o	me, date a opinion, de	and place, an eath occurred	d due to the c	ause(s) and ate and pla	manner as a	stated. to the cause(s)
To To To To To To To To To To To To To T	2	29b. Signature and	title of certifier	bopa A	ende	TH)	29c. Licens	e number	37/	2	9d. Date sig	gned (Month,	Day, Year)
Pas)		30. Name and addr	ess of person w	ho completed cause of a	death (Item	23a) (Type,		2	001 WN 40	MEDIO	-ofc	OKES /	(10)
State	9	31. Date filed (Mon	h, Day, Year)	07 32. Regist	rar's Signa	ture	de p	, ,	, , , , ,	1	PVLD	-	401

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept.15 Day 2007 Sear Physician Anthony Alfred Puca 4:50p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 / 0 1 / 1 9 2 1 9. Birthplace (State or Foreign Country) N • Y • , N • Y • **Funeral** 1**X** M 2 □ F 86 Months Days Hours Min 084-14-2431 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at MD Montgomery North Potomac Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15111 Jones Lane 20878 items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 9 4 1 — If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Major Appliances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Puca DeRosa ဥ Jeanette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 4 4 2 19a. Informant's Name/Relationship (Type, Print) 2175 Woodlands Way Camille A.Morse/Daughter Deerfield, Beach, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Chesapeake Crem. 9/17/2007 Beltsville, Md. 4 Donation 5 ☐ Other (Specify) 21. Signatur J Funeral Service Licens/ e PHILIP D. RINALDI FUNERAL SERVICE PA 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a I be detached f 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 70 1 Yes 2 No Other: 4□ Nursing Home 5□ Residence 6 Hother (Specify OSpice 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) To the Hospital or Autename, within 24 hours after death.

To the Funeral Director; Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOD64615 12 No 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroeblewski MD 6001 Muncaster Mill Rd.Rockville,Md20855 31. Date filed (Month De strar's Signature State Registrar

			T = For State Registrar		State of	Marylar	nd / Dep	artmer	nt of H			•		71111	31	401
	Physic		1. Decedent's Name (Audrey	First, Middle, Las	(1)				Phife	er		2. Date of De Month	D	ay Year	3. Time 1:30	of Death
	/Medi Exami		4a. Facility Name (If no		street and nun	nber)		4b. City	, Town, or	Location o	of Death	09/13/		c. County of Deat		
, lega			Maplewood	Park Pl	ace			Beth	esda				М	lontgomer	v	
	Funeral		5. Social Security Num	ber 6. Se		7. Age (In yrs.	**		r 1 Year	If Under :	24 Hrs. Min.	8. Date of Bi	rth		hplace (State untry)	or Foreign
100	Director	ļ	578 07 582 Usual Residence of De			95	Yrs.					Sept.		1912 DC		
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	th with the 23a or 28a	Funeral Director	10e. Street and Number 9707 01d (wn Rd.				p Code 814				-	Citizen of What Co		
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Mudical Examiner must be nettined at	by Funer	11. Marital Status 1 ☐ Never Married 3 🏅 Widowed 4 (_	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	ces? 2 😾 No		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	ncan Indian, e, etc. ite	
21215-0036	within 72 ho ene. than *natur	Completed by	(Specify Elementary/Seconda	5. Decedent's Ed only highest grad	ucation de <i>completed)</i> College (1	4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT L	ial Occupa ork done d ise retired,	ition Juring most)	of workin	g	16b.	Kind of Business/	Industry	
	filed wil Hygien other th	Con	12				Res	staur	ant M	lanage	er			Food		
Maryland	should be fill nd Mental His marked oth	To Be	17. Father's Name (Fir William F		m							(First, Middle Cthel (,		
, Mar	permit. Pages 1 and 2 should by Department of Health and Monta Importent: If item 27 is marked any injury or other traumatic en once.		19a. Informant's Name Carole A.			er								or Town, State, 2 Sburg, M		378
Baltimore,	ages 1 ant of He tr. If item y or oth		20a. Method of Dispos 14 Burial 2 0 4 Donation 5	Cremation 3 🗌	Removal from S	State	Place of Disponentery, cre	matory or o	me of other place	1	Da			Location - City or		
altir	partme portan portan portan		21. Signature of Fringer			1 Ce	edar H		nd Addres			·2007 eph Ga	Sui wle	tland, M r's Sons	Inc.	
m	Depa Impo any ir		W /m	thon M	unace									gton, DC		
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8760,	ate be executed hysicien and he burial-transit	dical Examiner	Sequentially list conditing to the cause. Enter Underlyi Cause (Disease or injurtati initiated events resulting in death) Las	ıry	Due to (c	Stage D	uence of).	a								
P.O. Box 6	the death certific. by the attending plached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent printhe past 12 mo 1 ☐ Yes 2 ☒ N 9 ☐ Unknown	nths?		th 2 ☐ Feta int at time of d	Ideath 3	Ectopic p Other (sp					a.	23d. Date of delined Month	very Day	Year
	uires that the de signed by the a Id be detached f	þ	Part II. Other significa Atrial Fi			ath but not res	ulting in the u	nderlying o	ause give	n in Part I.				use contribute to	the cause of	
Il Records,	Physician: The law requir this certificate has been si ral director, page 2 should i	Completed	Seizures								-	24a. Was auto perfo 1 Yes	psy ormed?	death?	topsy finding ompletion of 2 \(\text{No} \)	s available cause of
Vite	Sertific	Be	25. Was case referred examiner?	jes	Ha seitel:				1		of Death	Check only	one)			
ot	Phys this al dir	5	1 Yes 2 No			patient 2				42 <u>5</u> 2 1401				6 ☐Other (Spec	ify)	
O	ding h. After funer	tion	1 ⊠Natural 5	Pending investigation	28a. Date of (Month)	, Day Year)	28b. Time o Injury	M	28c. Injury Work	at ? ′es 2∐N		3d. Describe	now inji	ury occurred		
Division of Vital	tal or Attending Physician: s after death. el Director: After this certifica ed in by the funeral director, p	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Could not be determined	28e. Place o	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str					Bf. Location (City or To		and Number or Rule)	ral Route Nu	mber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exami	sician: To the I ner: On the ba and mann	sis of examina	wiedge, deat tion and/or in	n occurred vestigation	at the time, in my op	e, date and inion, deat	l place, an	nd due to the d at the time,	cause(:	s) and manner as nd place, and due	stated. to the cause	(s)
	To the within company	Σ	29b. Signature and title	of certifier	[/			D	3579.					ate signed (Month	, Day, Year)	
	15		30. Name and address	of per of who co	ompleted cause	of death (Item	CTV.	120	JJ/7.	L		(73/T	7/2007		
No.			Merlyn Ver	nury MD	9801 Ge	orgia A	Ave. #:		ilve:	Spr	ing,	MD 209	902			
	State Registrar 31. Date filed (Month Ser Yar) 8 2007 32. Projector's Signature															

State of Maryland / Department of Health and Mental Hygien 00 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month .Kantaben В. Patel 2:00 MP September 8, 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crisfield Motel Best Value Inn Crisfield Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🕱 F Director 74 215-15-8449 5/1/1933 India Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Somerset 1X Yes 2 □ No Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 30334 Pine Street 21853 USA death Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: Indian 'natural', ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event, 9DE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shanabhai Patel Sonaben Patel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ashok Patel/husband 30334 Pine St., Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 9/10/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer Physician breas t Wilh disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) motel Certification: To 1 TYes 2 No 1 Inpatient 2 ER/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death After 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending death. nours after death nerel Director: / / filled in by the fi investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \triangle 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin) 5146, Satisticy, MD, 21864 nouta 31. Date filed (Month, Day, Year) 32. Register's Signature State 13 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:50 a. M James Johnson Phillips Jr. 14 Sept. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester 5516 Bonnie Brook Road Cambridge If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 3 M 2 □ F 59 15, 1947 Maryland Director 218-48-7334 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar admirment of Health and Mental Hygiene. Admirment of Health and Mental Hygiene. Ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ortant: If item 27 is marked other than "natural", and injury or other traumatic event, the Medical Examiner must be notifiled at Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Cambridge Dorchester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 5516 Bonnie Brook Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 $^{\circ}$ 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) wire cloth mfg. commodity specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson Phillips Barbara Ann Creighton James ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a important: If item 27 is any Injury or other trau Mildred Phillips wife 5516 Bonnie Brook Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 9/18/07 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piration Physician /Medical Due to (or as a consequence of): Examiner tiple Pars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy pertormed¹ 1 Yes 2 🔀 I 2 No the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 4 ☐ Nursing Home 5 🗖 Residence 6 ☐ Other (Specify) Certification: To after death. Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 ☐ Homicide 24 hours a 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 300.1 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Mark Malkus, M.D. 408 Byrn St., Cambridge, MD 21613 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **SEP 1 8 200**7 Registrar

			For State Registrar	State of	Marylar	nd / Depa	artment of rtificate of	Health a	and Me	ental Hyg	iene _{eg. No.} 2	2007	3 1	+04
			1. Decedent's Name (First, Middle, La	ist)						Date of Deat	th		3. Time of I	Death
	Physici /Medio		Lorraine Li	llian	Rumps				S	Month Septemb	er 13	Year 2007	3:55	\mathbf{p}^{M}
	Examir		4a. Facility Name (If not institution, give	e street and num	aber)		4b. City, Town,	or Location of	of Death		4c. Cc	ounty of Death		
			Casey House				Rockv					ontgome		
L	Funeral		5. Social Security Number 6. S 325-12-7174	Sex 1□M 2.24 F	7. Age (In yrs.		If Under 1 Year Months Days		Min.	B. Date of Birth (Month, Day,	Year)	Cour		Foreign
b	Director		Usual Residence of Decedent		87					Jan. 01	, 192	20 111	inois	
	yland yow at		10a, State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City	y Limits
	a-f sh ified	itor	Maryland Montg	omery		01ney							1 🗌 Yes	2₩No
	or 28	Directo	10e. Street and Number		,		10f. Zip Code		· ·	1	0g. Citizer	n of What Cour	itry?	
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	tems	Funeral	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	igin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Americ Black, White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dat	9		1 □ Yes 2 ¹ No				St	pecify:		
ş	tural sal E	edt	15. Decedent's Ed		ies.	16a, Dece	dent's Usual Occi	nation		- 1	16h Kind	of Business/Inc	hite	
212	nin 72 n "na Medic	Completed	(Specify only highest gra		Acc F. \	1 (Give	kind of work done DO NOT use retir	e durina mas	at of working	,	TOD. Paring	Of Dusiness/III	Justry	
77.	d with giene er tha the I	mo.	8	College (1-	401 5+)	Ho	memaker					Own Ho	ome	
9	al Hy l othe	Be C	17. Father's Name (First, Middle, Last,)				18. Mothe	er's Name (First, Middle, N	Maiden Su			
<u>Xa</u>	Suld by Ment arked arked atic e	To	Robert Leon Niw	czyk						e Augus				
Лаг	2 sh and is m raum		19a. Informant's Name/Relationship (,		19b. Mailir	ng Address (Stree	et and Numbe	er or Rural	Route Number,	City or To	own, State, Zip	Code)	
≤ ovî	l and Health Im 27 Ther t		Carol Rumps / Da	aughter	Took 1	3206	St. Flor	ence T						
وّ	ages in the fire		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		tate	cemetery, crei	sition (Name of matory or other pl	i i	Da		20c. Locat	tion - City or To	wn, State	
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	, v	4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	-	Ft.	Lincol	ln Crema	tory	9/19/	2007	Bren	twood,	Maryla	ınd
g	Deps Impo any I	i y	21. Signature of Pulled at Service Ricer	1566		110	Name and Add Simple T 040 Rock	ribute ville	Fune	ral and	d Cre	mation	Center	852
	11-5		23a. Part/l. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deat							rialyle	Approximate Interval Betw	
y i	Physician	8	Immediat cause (Final disease or condition		Cancer							71	Onset and D	
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8/00,	cate be executed physician and the burial-transit	dical		, d										
Ó	tificat g phy as th													
ŏ	th certific ending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome pf pregna th 2 ☐ Feta		Ectopic pregnan	01/			23d	. Date of delive	ry	
2.0	e death he atten ed for u	sici	in the past 12 months? 1 ☐ Yes 2 🗷 No		nt at time of d		Other (specify)					Month	Day Ye	ear
7	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Phy	9 Unknown			(A) I Ab	4.4.							
S,	ires the signer of the d	ģ	Part II. Other significant conditions of	ontributing to dea	ith but not res	uiting in the ur	nderlying cause g	iven in Part I.		1		contribute to th		
cords	requ	Completed								11116	s 2 1	VO 3 □ P10D	ably 4. K Ur 	ikriown
ย	e law has b je 2 s	mpl								24a. Was ar autops	y -	4b. Were autor prior to cor	osy findings a npletion of car	vailable use of
	n: The licate har r. page		05 W							perform 1□ Yes 2	led? ⊠No	death? 1 ☐ Yes	2□ No	
V II G	sicial certii recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		500	Ot	hor:		Check only one				
5	Phy arthis aral di	\vdash	27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of	1 JUDON	4 LI NU!		d. Describe ho		Other (Specify	Hospic	:e
5	nding n. Afte	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		, Day Year)	Injury	28c. Inju Wo M 1	ork?]Yes 2∐N			,,	5541154		
2	Atter	ifica	3 Suicide 6 Could not be 4 Homicide determined	20e. Flace u	of injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, office	· · · · · · · · · · · · · · · · · · ·	28	f. Location (Str	eet and N	umber or Rura	Route Numb	oer,
5	ottal or urs afte vral Oil	Certification:								City or Town	,			
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral ulrector. After this certificate has completely filled in by the funeral director, page 2:	edical	29a. Certifier 1	ysician: To the bas niner: On the bas and manne	sis of examina	wledge, death ition and/or inv	occurred at the five stigation, in my	time, date and opinion, deat	id place, an ith occurred	d due to the ca I at the time, da	iuse(s) and ate and pla	d manner as st ace, and due to	ated. the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier	, //	2		29c. Licen	se number		29	d. Date și	igned (Month, I	Day, Year)	
	3		Blemene 1	INO CO	Jr_	w)	DC	064615	5		9/1	13/2007		
			30. Name and address of person who			, , , , .	Print)							
			Genevieve Wroble 31. Date filed (Month, Day, Year)				ard Driv	re #100), Roc	ckville	, MD	20850		
	Sta Registra		SEP 1 8 2		istrar's Signa		look .							

/Medical **Examiner** The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-trar signed by the a d be detached for page 2 or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

၉

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

Carrie Carrie	Huis	9013 Annapolis Roa	d Lanham, M	20706
23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death. Do not one cause on each line. Seosis	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of)			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United Services of Injury that initiated events	b Due to (or as a consequence of)			
resulting in death) Last	Due to (or as a consequence of)			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in th	ne underlying cause given in Part I.		se contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐Unknown
			24a. Was an autopsy performed? 1□ Yes 2 🕱 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence	Tother (Specify) Hospice
27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injury at	28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1 ☐ CertifyIng Pr (Check only one) 2 ☐ Medical Exam	nysician: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier	Me Co	29c. License number D0064615		e signed (Month, Day, Year) cember 14, 2007
30. Name and address of person who	completed cause of death (Item 23a) (Ty	pe, Print) 6001 Muncast	er Mill Road	i

State Registrar

Genevive Wroblewski, M.D.

Rockville, MD 20855

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Billy Dale Sissom, Sr. September 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 68 Chads Way Port Deposit Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Pay Year) 8/23/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F 85 Texas Director 460-22-9683 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Cecil Director Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 68 Chads Way 21904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 TXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Assoc. Director U.S. Govt. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumaths anone. 17 Father's Name (First Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alton Howard Sissom Willie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth H. Sissom (Spouse) 68 Chads Way Port Deposit, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 9/28/07 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Lutheran Cem Aberdeen, Maryland 21. Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 K Ce 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CANCER PROSTATE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ig pnysician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPERTENSION ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Registrar's Signature Communication of the Commu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SEPT. **Physician** Day 303 M HELEN FAYE SALTZ /Medical 2007 Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL RUSBURY Nicomics If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 21 F Days 214-32-0325 75 Director May 6, 1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Director Maryland Somerset Crisfield 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26675 Old State Road 21817 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-Owner 12 Furniture Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard W. Ward Fannie Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Saltz (Daughter) 26669 Old State Road - Crisfield, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridae Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 9/17/07 Crisfield, MD 21. Signature Funeral Service L 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshaw Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 EPSIS 5 days /Medical Due to (or as a consequence of) Examiner ALLIE MYOCHRDIAL INFRACTION Sequentially list conditions, Examiner If any leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed PULMONARY EM BOLISM Due to (or as a consequence of): burialphysician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 Accident 2 🗌 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: ours after death.
neral Director: A
filled in by the ft within 24 hours a

To the Funeral I

completely filled To the

> State Registrar

Medical

(Check only

29b. Signature and title of certifier

DR. USIM NATES AN

CARROLL ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

SAlisbuny Md. 21804

29d. Date signed (Month, Day, Year)

September 15/4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15, Virginia G. Smith September 2007 12:55 a M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. 1 Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days 578-60-7839 Hours 1 □ M 2√□ F 65 Yrs June 2, 1942 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 600 Stonington Road 20902 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine. 1 Yes 21 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Huggins Grace Cripps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Smith/Husband 600 Stonington Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1K Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Each trans Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Arrest disease or condition resulting in death) Due to (or as a consequence of) Cervical Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specity) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Matural n 24 hours and.

The Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47612 September 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue, Bethesda, MD 20814 Paul MacKoul, M.D

Registrar

State

31. Date filed (Month, Day, Year) SEP 1

18

2007

32. Bigistrar's Signature

			1 - State Registrar	ate of Maryland / L	Departme Certifica	nt of Health Ite of Death	and Me h	nıaı mygler Reg. I		31409
	Physici	an	Decedent's Name (First, Middle, Last)	· Cima				Date of Death Month Sept. 16	Day Year	3. Time of Death 6:25a M
	/Medic Examin		Lester Frankl 4a. Facility Name (If not institution, give street			y, Town, or Location			4c. County of Deat	
	LXamii	ICI	2507 Glenallen A	ve. #3		lver Spr			Montgor	nery
	Funeral Director		5. Social Security Number 225-24-4968 C. Sex W. M. Usual Residence of Decedent	7. Age (In yrs. last bin	Yrs. If Und Month	er 1 Year If Under S Days Hours	Min.	Date of Birth (Month, Day, Yea 5 / 26 / 19	9. Birtl 22 Tei	nplace (State or Foreign untry) nnessee
	/land		10a. State 10b. County	10c. City, Town	n or Location					10d. Inside City Limits
	Man e-fsh	tor	MD Montgomer	y Silv	ver Sp	ring				1 ☐ Yes 2 ☐ No
	th with the	ai Dire	10e. Street and Number 2507 Glenallen A	ve. #3		² ip Code 20906		10g.	Citizen of What Co USA	untry?
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than "natural", or itama 23a or 28e-f show any injury or other traumatic avant, it a Medical Evant, at minist be codified at once.	by Funeral Director	1 Never Married 2 Married 1	/as Decedent Ever in U.S. med Forces? ☐Yes 2 ☐ No 1944- Yes, Give ear or Dates: 1945	-	edent of Hispanic Coecify Cuban, Mexico		y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: W	
5	72 ho	ted	15. Decedent's Education (Specify only highest grade corr		Decedent's Us	sual Occupation	net of working	16b.	Kind of Business/	Industry
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7	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	4				First, Middle, Maid		ce co.
<u> </u>	Aental Aental rkad c	To Be	Lester Franklin	Hartles		Ma	ary Tu	attle Ga	aylord	
2	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (Type, P		_	ss (Street and Num				
≥ ນົ	t end teelth mm 27 ther tr		William A. Simmons 20a. Method of Disposition							,Md20906
	ment of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State Thorr		Cemeter		2007		on,Virginia
20	permit. Departr Imports any inju		21. Signature Funeral Service Licenses 23a. Part1. Enter the disease, or complication	OS.		and Address of Fac P D.RIN Columbi				
			snock, or neart failure. List only one cal	ns that caused the death. Do ruse on each line.	not enter the mo	ode of dying, such a	s cardiac or r	espiratory arrest,		Approximate Intervat Between Onset and Death
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiac Myx	oma					6 mo.
	Examiner			Due to (or as a consequence	of):					
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	rificate be executed 19 physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c	Due to (or as a consequence	-4)					
3	be ex sicien buria			Due to (or as a consequence of	01).					
	ificate g phys as the	edical	d							
	ath cer attendir or use	Physician/M	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	3 □Ectopic 5 □ Other (23d. Date of deli Month	very Day Year
	that the de ned by the e detached t		Part II. Dther significant conditions contribut	ting to death but not resulting in	the underlying	cause given in Part	t I.	23e. Did tobacc	o use contribute to	the cause of death?
3 .	quires in sign	ed by	Renal Failure					1 ☐ Yes	2 ∑ No 3 ☐ Pr	obably 4 Unknown
201	The law require sete hes been sin page 2 should t	Completed				, u maye		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
	certifical	BeC	25. Was case referred to medical examiner?			26. Plac	ce of Death (0	1⊡ Yes 2⊠ Check only one)	10 103	2010
5 2	Attending Physician: r death. sctor: After this certifice by the funeral director, 1	၉	1 ☐ Yes 2 🔀 No Hospit	1 Inpatient 2 ER/Ou					6 □Other (Spec	erfy)
5	ding h. After funer	tion	1 Natural 5 Pending		ime of njury M	28c. Injury at Work? 1 ☐ Yes 2		d. Describe how in	lury occurred	
IS A	or Atten after deat Director: in by the	Certification:	2 Could not be	e. Place of Injury - At home, fa building, etc. (Specify)				. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fun	edicai C	(Check only 2 Medical Examiner: C	To the best of my knowledge the basis of examination and manner stated.	, death occurre	ed at the time, date a on, in my opinion, de	and place, and eath occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
:	ro the Mithin Fo the	Me	29h Signature and hije of certifier	1	2	9c. License number	r	29d. I	Date signed (Monti	n, Day, Year)
	12		(Toll)	lasertone	Jes !	D 543	78		Sept.17	,2007
	100		30. Name and address of person who complete		Type, Print)		1	11		
			Cheryl Ayleswor	th MD 27:	30 Uni	versity	Blvd.	W Wheat	on, Md 2	20902
	Sta Registr		SEP 1 8 2007	32. Agistrar's Signature	Special .	5				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day George SIMBALL 12:47 P^M /Medical 2007 Sept. 16, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth Aug. 14, Year)916 Birthplace (State or Foreign Country)
 New York Sex 7. Age (In yrs. last birthday) **Funeral** 91 Director 527-30-9007 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Montgomery Village r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Montgomery Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20886 18700 Walkers Choice Road #505 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must I once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Executive 11 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Fannie Horowitz Louis Simball ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State Zin Gody) illage, Ruth Simball, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Lebanon Cemetery Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 09/18/07 21. Signature of Fun r (Service Li የዕነሚተነሳሌ የም ተሞታኮew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Vear signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was autopsy performed? certificate 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury ours after death.

neral Director: A
filled in by the fu 1 🗌 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifler Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Mopth, Day, Year) D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dr. Rockville, MD 20850 ELSAYYAD 9315 Medita strar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland /		rtment of F tificate of			2007	31411
	Physici		1. Decedent's Name (First, Middle, Last) Ernest G.	Schein				2. Date of Death Sept. 1	3 ^{Day} 2007 ^{ear}	3. Time of Death
9 (m)	/Medio Examir Funeral		4a. Facility Name (If not institution, give since the brew Home of 5. Social Security Number 6. Sex	Washington 7. Age (In yrs. last b	pirthday)_	4b. City, Town, or Rocky If Under 1 Year Months Days		8. Date of Birth	4c. County of Death Montgoi Year) 9. Birth Cou	
C.	Director		Usual Residence of Decedent	^{M 2□ F} 92	Yrs.			3/27/1	915 Ne	w York
	Marylar 8-f ehow	tor	MD 10a. State Montgome	ery 10c. City, To	wn or Loc ckvi					10d. Inside City Limits 1 X Yes 2 No
	with the	al Dire	10e. Street and Number 10114 Vanderbui	lt Circle		10f. Zip Code 20850		10	g. Citizen of What Cou U.S.A	-
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merial Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Medical Expriner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 122Yes 2 □ No 1942 If Yes, Give Year or Dates: 1945	2 - "	/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	rithin 72 h ne. nan "natu n Wedical	nplete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D		during most of worki	ng	Medica	
	e filed withial Hygiene.	Be Cor	12 17. Father's Name (First, Middle, Last)		ortno	opeaic	Technici	(First, Middle, Ma		
Maryland	2 should be and Menfal Is marked o	2	Roger Schein 19a. Informant's Name/Relationship (Typ	pe, Print)	b. Maiting	Address (Street		reumann	City or Town, State, Zi	p Code)
	1 and 2 : Health ar tem 27 is		Ronnie G.Schein	/Daughter 1	011		rbuilt (Circle 1	Rockville	,Md20850
Baltimore,	permit. Pages to Department of Himportant: If Ite any injury or ot any injury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	cemet	ery, crem.	atory or other place	(e)		wnshp•of	Wash., N.J
Balt	permit Depart Import Any in		21. Signatur Funeral Service Lice is a	D:	₽ 1	TTLTP*dD	SRTWALDI umbia B]	FUNERALVd.Silv	AL SERVIC ver Sprir	CE,P.A. ng,Md20910
,8760,	Physician and was the prize be executed by scien and physician streams it is prize to prize the prize that the prize	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heartfailure. List only one immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	4		ar ac	7	Approximate Interval Between Onset and Death
.O. Box 68	ne death certi the attending hed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	,		23d. Date of dein Month	very Day Year
α,	uires that the signed by id be detact	ρ	Part II. Other significant conditions cont	ributing to death but not resulting	in the und	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	: The law requir cete has been si page 2 should	Completed	70					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient	3□ DOA Oth	26. Place of Death		ce 6 □Other (Speci	ifv)
Division of	ding After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		. Time of Injury	28c. Injun Wor	y at	28d. Describe how		,,,
Divis	5 T T	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	e mr		29c. Licens	e number	290	d. Date signed (Month)	Day, Year)
	12		30. Name and address of person who cor	Senson / Ll mpleted cause of death (Item 23a) (Type, P	Print)	035/68	5	7/13/0	
			31 Date filed (Month-Day Year)	32. Paristrar's Signature		6121	Montre	se fal	Rocker	dle MD
	Sta Registr	-	31. Date filed (Month Day Year) 8 20	107 Secret 10	B	marks)				

			For State of Maryland 1 - State Registrar		rtment of He tificate of D		ientai Hyg _B	eg. No 200	17 31412
	Dhysici		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Beverly Beatrice Scafide					13, 2007	8:40 PM
,	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of	f Death
			Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. le	et hirthday)	If Under 1 Year	ville	8 Date of Birth	Montgo	omery 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🗷 F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) Sept. 28.		ashington, DC
	D		Usual Residence of Decedent				Sept. 20,	1,72J IVIC	
	arytar show	Ž	10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits 1
	the M	Director	Maryland Montgomery 10e. Street and Number	Gai	thersburg 10f. Zip Code		1	Ioa. Citizen of Wh	Α
	with the r		#5 Midsummer Court		20878			USA	
	ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	i. 13. v	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian, White, etc.
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1	Yes 2 13 No	Specify:	riicari, etc.)	Specify:	'
5-0036	72 hou natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of worki	ing I	16b. Kind of Busi	iness/Industry
2	be filed within 72 hc ntal Hygiene. ed other than "natun event, th∘ M. dical	mple	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired) naker			Own Ho	ome
7	filed v Hygie other t		8 17. Father's Name (<i>First, Middle, Last</i>)	1.0.11.		18. Mother's Name	(First, Middle,		
<u>a</u>	lid be ked o	To Be	Charles Daly			Catherine	Gilhoole	[°] y	
Maryland	2 should be and Mental Is marked aumatic ev	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	nd Number or Rura	al Route Numbe	r, City or Town, St	itate, Zip Code)
	and 2 ealth a n 27 ls		Thomas A. Scafide/Son	5 Mids	ummer Court,	, Gaithersh	urg, MD 2	.0878	
Baltimore,	of H	2	1 ABurial 2 Cremation 3 Bemoval from State	emetery, cren	sition (Name of natory or other place ven Cemetery	Sept.	18,		City or Town, State
Saltii	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	F22	Name and Addres			inc.	ring, Maryland
	= « O	6 0	23a. Patt. Enter the disease, or complications that caused the death		O University				20901 Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	. Do not ent	er tile mode of dying	g, sucii as caidiac i	or respiratory an	est,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Funture 4 euro Due to (or as a consequence)						12 Hours
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	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):					
	ecute and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C	ence of):					
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יע סי	s that ned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resu	Iting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
ğ	w require been sig should b						1 🗆 Y	'es 2□No 3	3 ★Probably 4 □Unknown
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Ita		ø	25. Was case referred to medical			26. Place of Deat		-A	
	Physician: this certific al director,	To B	examiner? 1 Tyes 2 to No Hospital: 1 to Inpatient 2 to E	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing Ho	me 5 🗆 Resid	lence 6 DOther	r (Specify)
o uo	Ing I		27. Manner of Death 1	28b. Time of Injury	Work	rat ? ∕es 2 □ No	28d. Describe h	ow injury occurred	d
Division or	i Sir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hon building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	er or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of examinat and manner stated.						
		Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, Day, Year)
•	20		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	1356	7 -	sept.	7007
	Sta	to.	31. Date filed (Month, Day, Year) 32. Rysistrar's Signat	VA-	9715 m	eoust c	enter	Orive a	(Month, Day, Year) 14 TH 7007 70850 ROCKSIIIE MO
	Registi		SEP 1 8 2007 Streve .	1. 19	medi				

				1 - For State Registrar	State of Ma		d/D	epartment of Certificate o	Health and M		giene (107	31413
		Physici /Medic		1. Decedent's Name (First, Middle, Las	- Sh	eri	da	•		2. Date of Dea	Pay	300° 7	3. Time of Death
2		Examin Funeral Director	er	5. Social Security Number 6. S 218-46-8918	neral th	(in yrs. 60		Be-		8. Date of Birtl (Month, Day 1/24/19	lie	9. Birthpl	lace (State or Foreign
18/		Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Worcest	er		y, Town	or Location				10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
2007		3a or 28e	Funeral Director	10e. Street and Number 108 Upshur Lane				10f. Zip Code 218			10g. Citizen US	of What Coun	try?
15/51/1	036	within 72 hours after death with the Maryland ene. then netural; or iteme 23a or 28e-f ehow fra Medical Examiran meat be cotified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1		.S.	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Speuban, Mexican, Puerto No <i>Specity:</i>	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, o ecify: Whi	etc.
S.	21215-0	within 72 ho liene. r then *natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or : 2	5+)		Decedent's Usual Oct (Give kind of work doi life. DO NOT use ret chanic	cupation ne during most of worki ired)	ing		of Business/Inc	dustry
1168-91-	yland ;	should be filed ind Mental Hygie a marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last, John Alfred Sher	idan				18. Mother's Name Myrtle V	iola Ke	tchum		
96-81	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natu any injury or other traumatic event, it a Madical any injury or other traumatic event, it a Madical ance.		19a. Informant's Name/Relationship (Doris L. Sherida 20a. Method of Disposition 1 Burial 2 Cremation 3	an / wife Removal from State	1	10 Place of cometery	8 Upshur I Disposition (Name of c, crematory or other p	1 .	n, MD 2	1811 20c. Locat	ion - City or To	own, State
812#5	Baltin	permit. Pa Departmer Important any injury once.		4 Donation 5 Other (Special 21. Signature of Funeral Service Lices			rae		dress of Facility Bur Liam St., B	bage Fu	nera1	Home	TID
5		Physician /Medical	<	23a Part 1. Enter He disease or com shock, or heart partie. List only Immediate Cause (Emal disease or condition resulting in death)	plications that cause one cause on each in a. Due to (or as	yst	em	ot enter the mode of					Approximate Interval Between Onset and Death
	760,	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. No C Due to (or as c. Due to (or as d. Vent	a consec	quence o	Entarc	HON Idosis	CLAMO	onka		
+	Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	of pregna	ancy al death	3 □Ectopic pregna 5 □ Other (specify			23d	I. Date of delive	ery Day Year
Rober	rds, P.O.	quires that the signed by ald be detact	ed by Phy	Part II. Other significant conditions	contributing to death I	out not res	sulting in	the underlying cause	given in Part I.		obacco use Yes 2 1		he cause of death?
an,	Vital Records,	8 8 6	Completed							24a. Was autop perfo	osy ormed?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
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herid	of V	Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital:		ER/Out	ipatient 3 DOA	Other: 4 Nursing Ho				fy)
Sh	Division o	Attending in death.	Certification:	27. Manner of Death 1. Attural 5 Pending investigation 3 Surcide 6 Could not be determined.	90 Place of In	ay Year) ijury - At h	iome, fai	njury '	injury at Work? 1 Yes 2 No	28d. Describe 28f. Location (City or To	Street and N		al Route Number,
	۵	To the Hospitei or within 24 hours afte To the Funerel Dir completely filled in	Medical Cer	29a. Certifier 1 Certifying P	hysician: To the bes miner: On the basis and manner s	of examina	owledge ation and	, death occurred at the	ne time, date and place, ny opinion, death occur	and due to the red at the time,	cause(s) an date and pl	nd manner as s ace, and due t	stated. o the cause(s)
		ro the vithin ro the	Me	29b. Signature apprtitle of certifier	· /			29c. Lic	cense number		29d. Date s	signed (Month,	Day, Year)

Name and address of person who completed cause of reath (Item 23a) (Type, Print)

24 5 0 1 m m 9 933 Health way Drive Borton mo 218/1

Pate filed (Month, Day, Year) 32, Registrar's Signature 31. Date (led (Month, Day, Year)
SEP 1 8 2007 ET 6+1 State

D64645 Sept 16 2007

Sperke

Registrar

			For State Registrar	State of	Maryland		artment of H		and Me		giene (07	314	14
4.6	Physici	212	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath Day	Year	3. Time o	
B	/Medic		Murrell		М		Simms			9	12	200		5 A M
	Examin	er	4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, or	Location of	of Death			unty of Deat		
30			4898 Cooper Roa 5. Social Security Number		. Age (In yrs. la	ast hirthday)	Eden If Under 1 Year	If Under:	24 Hrs.	B. Date of Birt		comic		or Foreign
b	Funeral Director		217-80-2581	1 □ M 2)X F	81		Months Days	Hours	Min.	(Month, Da	y, Year)	Vir	hplace (State i untry) ginia	si r Greigir
Ш			Usual Residence of Decedent										,	
	irylan show		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	City Limits
	8a-f	Director	MD Wicon	nico	Ede	n								2/1/10
	with th		10e. Street and Number				10f. Zip Code					of What Co	untry?	
	eath v	Funeral	4898 Cooper Roa	12. Was Dece	tent Ever in 11 5	S 13	21822 Was Decedent of Hi		gin? (Spec	rfv Yes or No	USA 14.	Race - Ame	rican Indian.	
	fter d	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed For	ces?		f Yes, specify Cuba	n, Mexican	n, Puerto R	ican, etc.)		Black, White	e, etc.	
93	al', o	þ	3 ₩idowed 4 □ Divorced	It Yes, Give Year or Da	,	10 to 10 to	1 ☐ Yes 21X No	Specify:			Sp	ecify: Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show tha Madical Exertinar maal be natified at	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired,	ation during most	t of workin	g	16b. Kind	of Business/	Industry	
2	hen.	ig I	Elementary/Secondary (0-12)	College (1-	4or 5+)						0	II		
,	Hygie ther t		11 17. Father's Name (First, Middle, L	ast)			Homemaker		er's Name	(First, Middle,	Own Maiden Su			
and	ould be filed v Mental Hygie wrked other t	o Be	Herma Lee Mora						Malo			•		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health are 1 is marked other than "natural, or itema 23a or 28a-f show other treumatic event. In Madical Exertings must be notified at	ဥ	19a. Informant's Name/Relationsh		- 11	19b. Mailin	ng Address (Street a				er, City or To	wn, State, 2	Zip Code)	
	alth a 27 is 27 is	M 1	Carole Moselev	- daughte	r	14896	Arvey Ro	ad. I	aurel	L. DE 1	9956			
altimore,	of Hei	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. PI	ace of Dispo	sition (Name of matory or other place			ite		ion - City or	Town, State	
Ē	Page ment: If ury o		4 □Donation 5 □ Other (Sp				emetery		9-16-				ryland	
Balt	permit. Pages 1 and 2 Department of Health s important: if item 27 li any injury or other tre		21. Signature of Funeral Service L	rensee	4	1	2. Name and Addres							
	40 E # 0		1/1/h550 \$	arry Bh	he		05 E. Mai				-	Maryla	and 218 Approxima	
			23a. Part1. Inter the disease, or shock, or heart failure. List of	only ne cause on ea	ich line.	,	~		cardiac or	respiratory ai	rrest,		Interval Be Onset and	etween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	creat!		cencer							-
	Examiner			Due to (d	or as a consequ	ience of):						and the state of t		
	*	e	Sequentially list conditions, if any, leading to immediate	b. — Due to (d	or as a consequ	ience of):								
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.										
,160,	e exertan ar urial-t	Ex	resulting in death) Last	Due to (d	or as a consequ	ience ot):						i de la companya de l		
ന	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit	dicai		d										
ox 6	death certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outo	come of pregnal	ncv					224	. Date of del	iven	
\mathbf{o}	atten atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 Live bi	nth 2 ☐ Fetal	death 3[Ectopic pregnancy Other (specify)				230	Month	Day	Year
0	the d by the ached	hysi	1 □ Yes 2 BUNO 9 □ Unknown	9□ Unkno										
۵.	res that the de signed by the a be detached f	by P	Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the u	nderlying cause give	en in Part I	l.	23e. Did t	obacco use	contribute to	the cause of	death?
ğ	w require been sig should b	edt								10	Yes 2	lo 3□Pr	robably 4	Unknown
Records,	has be	Completed								24a. Was autor	an 2	prior to	utopsy tindings completion of	available cause of
<u> </u>	The page	Con								perfo	28 No	death? 1 ☐ Yes	2 DNo	
Division of Vital	icien: certific ector.	Be	25. Was case reterred to medical examiner?	Hospital:			othe Othe	or		(Check only o	one)			
of	Phys this ral dir	- To	1 Yes No	1 L lr		ER/Outpaties 28b. Time o	IL JE DON	4 140	ursing Hom	ne 5 Resi		Other (Spe	icify)	
on	ding th. After	tion	Natural 5 Pending investig	9	f Injury n, Day Year)	Injury	Work	k? Yes 2□			,			
/isi	Atten r dea ector	ifica	3 Suicide 6 Could n	ot be 28e. Place	ot Injury - At ho	me, farm, st	reet, factory, office		2			lumber or R	ural Route Nu	mber,
٥	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 🗆 nomicide	Dulidin	ig, etc. (Specify	<i>'</i>)				City or To	WII, SIAIO)			
	hour hour uner			g Physician: To the Examiner: On the ba										(s)
	the H hin 24 the F	Medical	one)	and mann										
	To To	~	29b. Signature and title of certifier	<i>- //</i> /	M not	\	29c. License		7 C-				th, Day, Year)	
•	10		30. Name and address of person v	who completed as	V IV)	Da	60,	18		/-	. / 3	0 /	
	04		Out of E	D Coostal	Hrone	(1ype,	By 1733	Sen	lish	in	21	802	-07	
25	Sta	ite	31. Date filed (Month Shy, Sear)	3 2007 32. R	ustral's Signa	ture	Print) Bix (733	/))	01	<u> </u>		
***	Registi	ar		1	HORN	0	1000 M2							

			For State	State of Mary		ertificate of		nd Mental Hy	/giene Reg. No	7 311.15
e.	, A		Registrar Decedent's Name (First, Middle, La.	st)		Timodio or	Doutin	2. Date of D	eath	3. Time of Death
	Physici /Medic		Yiu Tze T	ung				Septem	ber 11, 200	
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of	f Death	4c. County of D	
			12321 Briarbush			Poton		2411	Montgo	
	Funeral		5. Social Security Number 6. S 212-31-8819	ex 7. Age (In ☐ M 2 ☑ F	yrs. last birthda; 87 Yrs.	Months Days		Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		07			Aprii	25, 1920	China
	nyland how	_	10a. State 10b. County	100	c. City, Town or I	ocation				10d. Inside City Limits
	e Ma Ba-f s	Director	Maryland Montgo	mery	Potoma	c				1 ☑ Yes 2 ☐ No
	with the		10e. Street and Number			10f. Zip Code	. ,		10g. Citizen of What	
	eath ns 23	Funeral	12321 Briarbush	12. Was Decedent Ever	in U.S. 13	2085 Was Decedent of I	•	in? (Specify Yes or N	United S	merican Indian,
٥	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 ☐ No		gin? (Specify Yes or N , Puerto Rican, etc.)	Black, W Specify:	hite, etc.
15-0036	hours ural",	d by	3 X Widowed 4 □ Divorced	Year or Dates:	10. 5		, , ,			Asian
င်	in 72 in "nat	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	ı (Gis	edent's Usual Occu re kind of work done DO NOT use retire	durina most	of working	16b. Kind of Busine	ss/Industry
717	d with giene. rr thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	emaker	,		Own Ho	ome
and	al Hy d othe	Be C	17. Father's Name (First, Middle, Last,)	_		18. Mother	r's Name (First, Middle	e, Maiden Surname)	
<u>yla</u>	ould b Ment arkec	To I	Unknown Ku					known		
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (_					ber, City or Town, State	, _,
	1 and Healt em 2:		Vincent Tung / 20a. Method of Disposition	Son 2		I Briarbu oosition (Name of ematory or other pla		ne, Potoma	c, Maryland	
D D	Pages nent of I unt: If its		1 Burial 2 Toremation 3 4 Donation 5 Other (Specif	Inemoval from State		ematory or other pla oln Crema	1	1/18/2007		od, Maryland
saitimore,	- + 4 + ·		21. Signature of Funeral Service Dicer			22. Name and Addre	ess of Facility	/		
ñ	Depar impor any Ir		M S. CA		1				and Cremati ville, Mary	
			23a. Part1 Enter the disease, of com shor, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dy	ing, such as	cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immedia vause (Final disease or condition resulting in death)	a. Coronary	Artery	Disease				Onset and Death 1 month
	/Medical Examiner		resulting in death)	Due to (or as a co						10
2		e	Sequentially list conditions, if any, leading to immediate	b. Hypertens Due to (or as a co						10 years
	cuted id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Š	e exectan ar	EX	resulting in death) Last	Due to (or as a co	nsequence of):					
8/00,	death certificate be executed e attending physician and of for use as the bunat-transit	dical		d						
Q X	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf pi	regnancy				23d. Date of	dolivon
POX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		Month	Day Year
S	t the c by the	hysi	9 Unknown	9□Unknown						
Š,	requires that the een signed by th	by P	Part il. Other significant conditions of	contributing to death but no	at resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
coras,	requir een si nould	ted	Hyperlipidemia					_ 10]Yes 2[x]No 3□	Probably 4 ☐Unknown
Tec C	e la has le 2	Completed								autopsy findings available to completion of cause of
ā	dcian: The certificate has ector, page		Of Manager with and the medical					1□ Yes	2 🖾 No 1 □ Y	es 2□No
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 I Innatient	2 ER/Outpati	ant 3 DOA Oti	har:	of Death (Check only	one) sidence 6 □Other (S	
0	ding Physician: After this certific funeral director,	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Ye.	28b. Time	of 28c. Inju			how injury occurred	респу)
VISION	endin ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending investigation	1	ar) Injury		Yes 2 N	10		
<u> </u>	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - building, etc. (S	At home, farm, s pecify)	treet, factory, office			(Street and Number or own, State)	Rural Route Number,
_	pltai	Ce	29a. Certifier 1 Certifying Ph	nysician: To the best of m	v knowledge de	ath occurred at the	imo dato an	d place, and due to the	o cource(c) and manne	as stated
	e Hos 124 hc e Fun letely	edical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated.	mination and/or	investigation, in my	opinion, deal	th occurred at the time	e, date and place, and	due to the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier	/		29c. Licen	se number		29d. Date signed (Me	onth, Day, Year)
)	2.		Nelson	Kump		D	43869		September	13, 2007
			30. Name and address of person who	·						
	Sta	to	Nelson Lui, M.D. 31. Date filed (Month, Ban Year)	32. Re Strar's	Signature		North	Potomac,	Maryland 2	0878
B	Sta Registr	_	31. Date filed (Month, SEP 1 8	2007 Julien	U.B.	Coarte				
						1	-			

DHMH 17 Rev 1/2001

		ľ	For State Registrar	State	of Marylan		irtment of H		nd Mental Hy	/giene Reg. No.?	007	211.16
- 3	Physicia	an	Decedent's Name (First, Middle)		DRED MAY				2. Date of D		2 Yor 7	3. Time of Death 9:07 PM
	/Medic Examin		4a. Facility Name (If not institution Frederick Memo	, give street and n	umber)	1022	4b. City, Town, or Frede			4c. Co	unty of Death	
_#	Funeral	d	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24	Hrs. 8, Date of B	irth	9 Rirthn	lace (State or Foreign
L	Director		188-09-2058	1□M 2√F		89 Yrs.	Months Days	Hours	May 16	• 1918	Penns	sylvania
	/land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Man Ba-f sh tiffied	Director	Maryland Frede	rick	Fr	ederic	ζ					1 X Yes 2 No
	with the	I Dire	10e. Street and Number 206 Grove Boul	evard			10f. Zip Code 21	701		10g. Citizen	of What Cour	•
	r death	Funeral	11. Marital Status	Armed I		.S. 13. \	Nas Decedent of H f Yes, specify Cuba	ispanic Origir an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0- 14.	Race - Americ Black, White,	
38	ırs afte al", or II xamln	by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Ar}Yes If Yes, 0 Year or	: 2□ No Bive Dates: WWII		I□Yes 2ŽNo	Specify:			ecify: Wh	
2-0	72 hou 'natura dical E	Completed	15. Deceden (Specify only highe	's Education		16a. Deced	lent's Usual Occup kind of work done o	ation during most o	of working	16b. Kind	of Business/Inc	dustry
121	within iene. than '	ompl	Elementary/Secondary (0-12)	College 4	(1-4or 5+)	1	oo NOT use retired icrobiolo			U.S	. Gove	rnment
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be C	17. Father's Name (First, Middle, Charles Angsta	•				18. Mother's Carri	s Name (First, Middle e Unknow		rname)	
	1 and 2 should Health end Men em 27 Is marke em traumatic	_	19a. Informant's Name/Relations Arthur C. Volpe	hip <i>(Type. Print)</i> / Husbar	ıd	19b. Mailin 206 (g Address <i>(Street</i> Grove Bou	and Number 1evard	or Rural Route Num l, Frederi	ber, City or To	own, State, Zip ryland	21701
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	II State I		sition (Name of natory or other place		Date		ion - City or To	
ᆵ	permit. Page Department of Important: If any Injury of once.		4 ☐ Donation 5 ☐ Other (S		Sm	$-\alpha$	g Cremat					Maryland
<u>8</u>	permi Depa Impo any Ir once		Lakest 1	6/7/	let	RO 12	OBERT E. 201 NORTH	DAILEY MARKE	& SON, FU	NERAL EDERIC	HOMES, K, MD 2	P.A. 21701
	Physician	7200	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition	eomplications that only one cause or	caused the dear	h. Do not ent	er the mode of dyir		ardiac or respiratory	arrest,		Approximate Interval Between Opset and Death
	/Medical Examiner		resulting in death)									
k	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due t	o (or as a consec	uence of):						
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	uence of):						
8760,	icate be executed physician and s the burial-transit	dical E										
9	certifica Iding ph	/Med	IF FEMALE:	23c. If yes, o	outcome pf pregn	ancy				234	l. Date of delive	904
Records, P.O. Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 18 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 □Live	e birth 2□Feta gnant at time of o	aldeath 3	Ectopic pregnancy Other (specify)	/		230	Month	Day Year
ds, P	uires that signed b	d by Pr	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.		tobacco use		he cause of death?
600 600	ne law requir has been si ge 2 should	Completed							24a. Wa	s an 2	24b. Were auto	opsy findings available mpletion of cause of
ية ع									pei 1⊡ Yes	formed? 21 No	death? 1 ☐ Yes	2 No
Vita	yslclan: Th s certificate director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hoenital: 1	and a line of the state of the	ER/Outpatier	it 3□ DOA Oth	or.	of Death (Check only sing Home 5 ☐ Re		Other (Specia	f ₂)
10 U	ding Phys n. After this funeral di		27. Manner of Death 1 Natural 5 □ Pendir	28a. Da	te of Injury onth, Day Year)	28b. Time o	f 28c. Injui Wor	y at k?	28d. Describ	e how injury o		<u> </u>
Division or	Attend death.	Certification:	2 Accident investi	not be 28e. Pla			M 1 □	Yes 2 □ No	28f. Location	(Street and N	lumber or Rura	al Route Number,
á	ital or after ral Dire	Certi	4 Tromicide	bu	lding, etc. (Speci					own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying	Examiner: On the	he best of my kp basis of examin anner stated.	owledge deat ation and/or in	h occurred at the ti vestigation, in my	me, date and opinion, death	place, and due to the occurred at the time	e cause(s) an e, date and pl	nd manner as s ace, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ce lifts	206	2/		29c. Licens	e number	7.	29d. Date s	igned (Month,	Day, Year)
)	AVI		30. Name and address of person	who completed as	use of death (Ite	m 23a) (Tvne	Print)	137	//	_7/	18/0	7
V	\mathcal{D}_{χ}		Robert L. Kauf	nann, MD	300 We	st 9th	Street,	Freder	ick, Mary	land 2	1701	_
	Sta Registi		31. Date filed (Month, Day, Year,	2007	Registrar's Sign	B A	ander)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #31 per FCHD 09-18-07 Commissionate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 15, 2007 **Physician** STEVEN SUMNER WEISS 8:06 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7255 Woodbine Road Woodbine Carrol1 8. Date of Birth (Month, Day, Ye Tan. 24, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday **Funeral** Year Days Hours 1 € M 2 □ F 577-68-8843 1951 Kansas 56 Director Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 ☐ No Maryland Carroll Directo Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21797 7255 Woodbine Road U.S.A. 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: Specify. 2 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) College Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Leonard Weiss Patricia Sharp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health and Important: If item 27 is rany injury or other traur George L. Weiss / Father 990 Waterford Drive, Frederick, Maryland 21701 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory 9/18/07 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Tyneral Service Lice met 2 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SONON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s performed? or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 70 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

the

State Registrar

(Check only

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6, 2007 WILSON SEPT. 7:20 P M DENNIS L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Layhill-Genesis Health Care Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | Dec. 15, 1964 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ★M 2 ☐ F 42 Marvland Director 213-82-5000 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any larry or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ⊈Yes 2 ☐ No Director MD Takoma Park Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20912 7620 Maple Avenue, #528 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Handyman Landscape Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Sewell Janet Wilson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Silver Rock Rd, Rockville, MD 20851 Janet Grady (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 🏖 💢 remation 3 ☐ Removal from State 5 ☐ Other (Specify) Riverdale Park Cre 9/21/07 Riverdale, MD 4 □ Donation 21. Ignature of Funeral Servic Consee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 1246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to Thrive /Medical Due to (or as a consequence of): Examiner Craniotomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and Due to (or as a consequence of) burialphysician Physician/Medical death certificate the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Septic Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Ventriculostomy autopsy has e 2 page certificate 1∐ Yes **XX**No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 ☐ Inpatient Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Matural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

P.O. Box 68760. or Vital Records, To the Hospital or Attending Division

neral Director: A hours after within 24 hours a

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and til

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4409 East-West Highway, Riverdale, MD 20737 Saadia Husain, M.D. strar's Signature

uski

8 2007

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064208

29d. Date signed (Month, Day, Year)

9/14/07

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11:31 12 2007 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In)rs. lace plin If Under 24 Hrs 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Number **Funeral** Months Days Hours 1 **S**M 2 ☐ F 53 Oct.27,1953 Kentucky Director 217-56-4093 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No MD Rockville Director Montgomery . 1 and 2 should be filed within 72 hours after death with the l Health and Mental Hyglene. tem 27 is marked other than "natural", or items 23a or 28a-10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20851 U.S.A. 2104 Lewis Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drug Tester Pre-Release Center yrs 27 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any in ury or other traumatic evoce. William H. Walker Thelma Bruce ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2104 Lewis Ave., Rockville, MD 20851 Kathleen Walker (Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Hopkins Cemetery: 9/22/07 Highland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Ignat e of Funeral Service 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner allune ves Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-trai Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a d be detached f 1 Ves 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy has The 1 death? 1 ☐ Yes eras after death.

eral Director; After this certificate I filled in by the funeral director, pag 2 No 1 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient P 27. Mapner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Hospitai 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 20 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause buttiware 600 gistrar's Signature 31 Date filed (Mon State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:40 PM 12, ALTHEA C. YOUNG SEPT. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 29, 1953 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Yrs. 53 212-60-2279 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at 1 □X es 2 □ No Director MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10006 Guilford Road 20794 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify 3 ☐ Widowed 4 ☐ Pivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) the Walter Reed vrs Ultra Sound Tech other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of pe Albert L. Young, Sr traumatic ပ Shirley J. Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luvear E. Owens, III (Son) Health lem 27 i 10006 Guilford Road, Jessup, MD 20794 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Guilford Mem. Park 9/19/07 4 □ Donation 5 □ Other (Specify) Columbia, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 21. Signature of Funeral Service Licenses TORA 246 N. Washington ST, Rockville, MD 20850 23a. Part 1. Enter nie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or h, art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a conse Examiner Sequentially list ou diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deal? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has perform 1∐ Yes Division or Vital 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ၉ 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month SEP 18 2007

John W.

me and address of person who completed cause of death (Item 23a) (Type, Print)

Payne, M.D. Johns Hopkins Hospital, Baltimore,

MD

21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Date Month 3. Time of Death Year **Physician** ANDREWS WAYNE 11:59 A.M 30 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKLIN HOSPITAL SQUARE oseda altimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Davs 214-26-2494 Director 1930 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 🛣No Harford Directo Maryland Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1801 Lamont Court 21047 items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Examiner 1 ☐ Never Married 2 ☐ Married 1 XYes 2 ☐ No If Yes, Give Year or Dates: 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: White þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) the 9 years Inspector Steel traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any lijury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Andrews Theresa Dorraugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13578 Deer Brook Court, Mt Airy, Maryland William Andrews son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 3, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 5 ☐ Other (Specify) Dundalk, Maryland 2007 21. Signatu Funeral Ser 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 480 **Physician** /Medical WITH RESPIRATORE FAILURE Examiner ISCHEMIC CARDIOMYOPATHY WITH CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 148-To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit CHRONIC MYELPPROLIFERATIVE DISEASE WITH THROMBOCYTOPENIA Due to (or as a consequence of): Box 68760 nding physician Physician/Medical DIABETES MELLITUS WITH NEUROPATHY AND RENAL PAILURE IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ CELLULITIS OF RIGHT 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed DIFFICILE COLITIS CLOSTRIDIUM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? BILATERAL PLEURAL RFFUSION SLEEP APNER 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient P 2 ER/Outpatient 3 DOA this After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: s after deau ral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) houralit, m. D D16306 04

State Registrar

31. Date filed (Month, Day, Year) 0 2 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELAIR RD

BALTIMOPE , MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 1- State Registrar Amend #15, perFH, 0872, 10/2/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1ARGARET 24 2007 NAGHO September /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OCTORS LANHAM PRINCE OMMUNITY GEORGE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1□M 2**X**F AMEROON Director UNKNOWN Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene, Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number MEADOWRIDGE MEROOM Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 MEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UNKNCLUN) Be 2 19a. Informant's Name/Relationship (Type. Print) , 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MEADOWRIDGE SOLOMON ANAGHO BOWIE MD ZOTZI timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SABRI. CAMEROON 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** UTE STROKE /Medical Due to (or as a consequence of): Examiner PERTENS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 12 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MDD 53066

State Registrar 31. Date filed (Mg)th, Day, Year)

909 Old Branch Ave.,

Clinton, MD. 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician 2:15 PM 00 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Specially Hospital Baltimore Unwersit 9. Birthplace (State or Foreig If Under 1 Year | If Under 24 Hrs. 6. Se last birthday, 8. Date of Birth **Funeral** Days Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number realer 14. Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECURITY GUARD BWI AIRPORT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MACK AUSTIN ပ DORIS R. JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 FREDERICK AVE., ROBERT AUSTIN, JR/SON BALTO. MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-01-07 BALTIMORE, MD METRO CREMATORY 21. Ignatur of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC BALTO. LAURENS ST., Approximate Interval Between Onset and Death 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical quence of) Due to lates a cor Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for the funeral director. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use cont to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 7 o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 21 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

3

31. Date filed (Month, Day,

Robert

2

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death. 3. Time of Death Day A M 09 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death inde DA FANDALISTOWN CET OLD Year) 18 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 24 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 🔊 🗆 F MD 214-12-2792 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Xes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 East Preston Street 21202 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietitian School System 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Massie Fortune 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1104 Mt. Holly Street, Baltimore, Md 21229 <u>Kenneth Baily-Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 10/4/07 owings Mills, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March F/H West Signature di Funeral Service Licensee 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Immy diate Cause (Final disc ase or condition resulting in death) HEART FAILURE CONGESTIVE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Johnnown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury

The law requires that the death certificate be executed Box 68760,

attending physician and for use as the burial-tran Division or Vital Records, P.O. signed by t d be detach After this certificate Hospital or Attending Physician:

Physician/Medical þ Completed Be P Certification:

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" any injury or other traumatic excessions.

Physician

/Medical

Examiner

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

Medical

29a. Certifier

(Check only one)

25. Was case referred to medical 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

057722

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEPTEMBER

M.D.

1838 GREENE TREE RUAP #300 PIKESVILLE MO 21208 LEGNARD RICHARDSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Berardino Michael Anthony SEPTEMBER 10:00FM 30.2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 1 XM 2 TF 47 216-80-9955 May 31,1960 Maryland Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Dundalk Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be r 21222 USA 4104 Beachwood Road death v Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ь 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 ☐ Widowed 4 X Divorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) **AT&T** Account Representative 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Joseph Anthony Berardino Anna Marie Bowen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzanne Berardino-Los 809 Monkton Road, Monkton, Maryland 21111 Sister Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 5, 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PERICARDITIS/CARDITIS DAYS /Medical Due to (or as a consequence of): **Examiner** STAPHYLOCOCCUS AUREUS Ozquentiany net curumone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CIRRHOSIS SECONDARY TO HEPATITIS C VIRUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an HISTORY OF INTRAVENOUS DRUG USE autopsy perform ¥⊒ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: npletely filled in by the 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

O ۵ Division or Vital Records, within 2.

To the I complet the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 0 D0060495

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAN. OSLER DRIVE M. D. TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

State

Registrar

0

Certificate of Death

14. Race - American Indian, Black, White, etc.

2:51 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 XYes 2 □ No

В			1. Decedent's Name (First, Middle, La				Date of Death Month	Day Yea	3.
	Physicia		Aaron D	Bailey			OCTOBER		07
1	/Medic Examin		4a. Facility Name (If not institution, giv		4b. (City, Town, or Location of Death		4c. County of De	eath
			University of Maryla	and Medical Co	enter 1	Saltimore		N/A	
-6	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. In	ast birthday) If U	nder 1 Year If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear) 9. B	Birthplace Country)
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	er de item	Į,	11. Marital Status 1 XNever Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	if Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Wi	
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ary	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship	Type. Print)	19b. Mailing Add	dress (Street and Number or Rui			
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Baltimore, Maryland 21215-0036	permit. Pa Departmen Important: any injury		21. Şignati re of Funeral Service Lice				Gineral	Saprice	7/1
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ŏ	h cer andin use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		pic pregnancy		23d. Date of	,
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ita	Physiclan: The la this certificate have ral director, page 2	Be C	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
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0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
<u>ö</u>	Attending Physician: r death. ector: After this certifica by the funeral director, p	atio	1 Natural 5 Pending 2 Accident investigation	n	M				
Division or Vital Records,	Attender death	ific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specifi	ome, farm, street, fa	actory, office	28f. Location (Stree City or Town,	et and Number or State)	r Rural R
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	in 24 he Fi	Medical	one)	end manner stated.	and of myoong			·····	
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License number	296	d. Date signed (Me	onth, Day

Jones City or Town, State, Zip Code) thenere, MARGIANN 21289 20c. Location - City or Town, State MORE, MARyland 21229 One week one week 23d. Date of delivery Month Year acco use contribute to the cause of death? es 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ned? 2 ☐ No nce 6 Other (Specify) w injury occurred reet and Number or Rural Route Number, 1, State) ause(s) and manner as stated. ate and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) AU4176435P18171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore MD 32 Registrar's Signature **ORIGINAL**

State Registrar

31. Date filed (Month, Day, Year)

Kelechi Princewill

OCT 0 2 2007

07-07242 John Paul Broll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31427

	1- For State Certificate of Death Reg. No.								01 0142					
Physicia			tarre (113), Wildie, Edit/							Date of Deat Month	Day	Year	3. Time of Death	
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		University Hospital Baltimore												
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und					If Under	_	If Under	_	3. Date of Birl	h (MM/DD/Y)	77Y) 9. B	irthplace (State or Foreign country)
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21215-0036 uld be filed wittin 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner		John Louis									zabeth			
21 Duld I Mer mar ic et	2	19a. Informant's Nan	ne/Relations	hip (Type, Print)			-					nber, City or	Town, Sta	ate, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teatth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Michael Br	:o11/B	rother	•		x 180							
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disp				. Place of Dispo					Date		,	or Town, State
Baltimore, permit: Pages 1 ar Department of Hee Important: If ite					I from State We	est Arur	idel (rema	tory	9-24	4-2007	Odent	.on,	Maryland
trine	/-	4 IRonation 5				- 0 22.	Name and	Address of	of Facility					
Balt permit Departi Importinjury		10-011		X 1) 11	MULAN	Ary Ary	brose	Fue	nral	Home	e, Inc.		MJ	21 227
Physician		23a. Part I. Enter the	disease, or	complications the	at caused the dea	th. Do not enter	the mode of	of dying, s	uch as ca	rdiac or r	espiratory arr	est, shock, o	r heart	Approximate Interval
Physician /Medicar	8 7	failure. List only	y one cause	on each line.					2	~				Between Onset and Death
xaminer	Н	Immediate Cause (F or condition resulting			nsive Atheros		llovascu	iai Dise	-ase					· · · · · · · · · · · · · · · · · · ·
eter				h	a donocquoned					,				·
	ē	Sequentially list con if any, leading to imi		Due to (or a	as a consequence	of):								
	듩	cause. Enter Under (Disease or injury th		C.										
p it	Examin	events resulting in o		Due to (or a	as a consequence	e of):								
760, Teate be executed physician and the burial - transit				d										
oe ex ician irial	edical	UNPENDED		AMENDE	ED .									
760, ficate be g physic the bur	/Me	IF FEMALE:	roenent in t		es, outcome of pr	egnancy			- I=				ate of deliv	
68 ertiff ding	ian	23b. Was decedent p past 12 months'			ve birth egnant at time of	donth	etal death		Ectopic	pregnand	СУ	Mor	ıtrı	Day Year
Box 68 death certif the attending	sic	1 Yes 2 N	lo 9 Un		nknown	death 5	Other (Spe	Cify)						
he de y the	Physician/M	Part II. Other signif	icant condi			t resulting in the	underlying	cause di	ven in Pa	rt I.	23e. Did 1	obacco use	contribute	to the cause of death?
P.O. es that the general by e detac	by	, are in ourse organi			.9	3	, ,				1 Ye	es 2 No	3 F	Probably 4 🗸 Unknown
S, F uires n sig Id be	eq						-				24a. Was	an I	24h Were	autopsy findings available
ord w req ss bee shou	olet										auto	psy		to completion of cause of
ecc he lav ate ha	Completed											ormed?	1	
n: T rtifica or, pi		25. Was case referr	ed to medica	al l				26.Place	of Death	(Check or	nly one)			
/ita sicia is cel lirect	o Be	examiner? 1 ✓ Yes	2 No	Hospital: 1	Inpatient 2	✓ ER/Outpatie	nt 3 C	OOA (Other:	Nursing	Home 5	Residence	6 0	ther:
of \ g Phy ter there are	-	27. Manner of Death		28a. E	ate of Injury	28b. Time o	f Injury	28c. Injur	y at Work	? 2	28d. Describe	how injury o	ccurred	
nding th. e fur	io	1 V Natural	5 Pen	ding (N	lonth, Day,Year)			1 Y	es 2	No				
SiC Atter r dea ector by th	cat	2 Accident		stigation 28e I	Place of Injury - A	t home, farm, st	reet, factory	, office by	uilding, et	c. 2	28f. Location	(Street and N	umber or	Rural Route Number, City
Division of Vital Records, tal or attending Physician: The law requir is after death. "I Director: After this certificate has been s'led in by the funeral director, page 2 should be	Certification:	3 Suicide		Id not be Spermined (Spermined							or Town,	State)		
ospite hour mera y fill		4 Homicide	0 "" "		best of my knowl	adaa daath aa	usend at the	n timo, da	te and nis	ace and c	lue to the cau	se(s) and m	anner as s	stated
he Ha in 24 he Fu pletel	ical		Medical Ex	mysician: To the miner: On the ba	sis of examination	n and/or investig	gation, in m	y opinion,	death oc	curred at	the time, date	e and place,	and due to	o the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical			and mann	er stated.			c. License		_				(Month, Day, Year)
	2	29b. Signature and	A certifi	. 1	11		29	O.C.N					nber 18	
4			V	M. 1	1			U.U.I	VI.⊏.			Septer	IDEL 10	, 2001
7		30. Name and addre	/							MB 6 :-				
1		Jack Titus N		· · · · · · · · · · · · · · · · · · ·	edical Examir	ner 111 P	enn Stre	et, Balt	ımore,	MD 212	201			
S	tate	31. Date filed (Mont			Registrar's Sign	nature	rolle 8							
Regis	trar	100	T 0 2	2007 . [4	18 10 12 M 1	No Asign	Contract of the last of the la							

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) SINAI HOSPITAL OF BALTIMOR

31428

3. Time of Death

12:40PM

N/A

10d. Inside City Limits

1XXVes 2 □ No

Birthplace (State or Foreign Country)

white

Approximate Interval Between Onset and Death

days

Maryland

USA

Year

,2007

State Registrar

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

TAZEEN. 31. Date filed (Month, Day, Year)

6 ☐ Could not be

OCT 0 2 2007

ehman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

GOSSE

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

REHMAN.

3. Registrar's Signature

State Registrar	Certi
For	State of Maryland / Depar

			1 - For State Registrar	State of Mi	Ce	rtificate of		менан пу	Reg. No.		31429	
6	The state of		1. Decedent's Name (First, Middle, La	st)				2. Date of De	eath Day	/ Year	3. Time of Death	
The second	Physici /Medic		Charlotte F					r 30 2007	405 PM			
	Examin	er	4a. Facility Name (If not institution, give		r Location of Death	•	-	County of Death				
	7		5. Social Security Number 6.5		e (In yrs. last birthday	Randall	Stown If Under 24 Hrs.	B. Data of Bir		Saltimor		
	Funeral Director		214–26–4359 Usual Residence of Decedent	1 M XX F 7. A9	78 Yrs.	Months Days	Hours Min.	8. Date of Bii (Month, Da Jul.	24, 1	929 Mary	ace (State or Foreign try) 1and	
	land ow tt		10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits	
	Mary Firsh	ţo	Maryland Baltimo	re	Owings	Mills					1 □Yes XXNo	
	th the or 282 anoti	irec	10e. Street and Number		3	10f. Zip Code			10g. Citi	zen of What Coun	try?	
	23a c	ra [100 Pleasant Hil	1 Road		2111			of A	ed State merica	5	
	er deg	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	 Race - America Black, White, 		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes XX If Yes, Give Year or Dates:		1 □ Yes XX No	Specify:			Specify: Whi		
5-("natu	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de</i> co <i>mpleted)</i>	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wor	king	16b. Ki	ind of Business/Inc	lustry	
121	filed within Hygiene. Ither than [†]	dmo	Elementary/Secondary (0-12)	College (1-4or 5	o+)	nemaker	2)			Own Ho	mo.	
	filed with Hygiene other than ent, the N	Be Co	17. Father's Name (First, Middle, Last)	1100	HEHIONEL	18. Mother's Nam	ne (First, Middle	, Maiden		alle	
lan	ould be a Mental I arked o	To B	Jacob Gerwig				Mabe1	Downs				
Maryland	2 should and Men Is marke aumatic	_	19a. Informant's Name/Relationship	Type. Print)	19b. Mail	ing Address (Street	and Number or Ru	ıral Route Numb	per, City o	r Town, State, Zip	Code)	
	1 and 2 Health a tem 27 is		Sharon D'Ambrogi	(Daughter)		rriedale	Court, C	wings M	li11s	, Maryla	nd 21117	
ore	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition ↑	Removal from State	20b. Place of Disp cemetery cre	osition (Name of ematory or other place N	oe) Oct	Date 4,	20c. Lo	cation - City or To	wn, State	
Ë	: Pag tment tant: jury		4 □ Donation 5 □ Other (Speci	(y)	Memorial	Park	: 200	7	Syke	sville,	Mary1and	
Baltimore,	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Sovice Lice	who .	1	2. Name and Addre Eckhardt 11605 Rei:	ss of Facility Funeral (sterstown	Chapel,	P.A. Owin	igs M ill s	, MD 21117	
10			23a. Part 5 ter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not er	iter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate interval Between	
	Physician		Immediate Cause (Final disease or condition Congestive Heart failure, Coulsing hupovia								Povia	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):		. ~		7	7, ~		
	Zammer	ř	Sequentially list conditions,	b. Due to (or as	Jo Carde	al Int	arctic	1				
	nted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C -	to a Dosc	lomais						
Ć,	execu n and ial-tra	Exal	Due to (or as a consequence of):									
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		_d	iabetes	Mellit	20-					
			IF FEMALE:									
Вох	eath cert attending		23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	у		1	23d. Date of delive Month	ry Day Year	
	that the desired by the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				Hona	Day Tou.	
P.0	that the the the the the the the the the th			Part II. Other significant conditions	contributing to death b	ut not resulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to the	e cause of death?
Records,	w requires that been signed to should be det	d by	Stroke					1 🗆	Yes 2[□ No 3 □ Prob	ably 4 Unknown	
000	aw rec s bee	Completed	, 0					24a. Was		24b. Were auto	osy findings available	
R	hysician: The law his certificate has b I director, page 2 s	omp						auto perfe 1□ Yes	psy ormed? 2 No	death?	npletion of cause of 2 □ No	
ita		Be C	25. Was case referred to medical examiner?				26. Place of Dea			1 1 1 1 6 3		
or Vital	<u>~ .≅</u> ₽	To	1 ☐ Yes 2 No	Hospital: Impatie			4 ⊔ Nursing H	ome 5□Res	idence	6 □Other (Specif))	
n	fte		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	Wor		28d. Describe	how injur	y occurred		
Division	Attending r death. ector: After by the fune	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of ini	ury - At home, farm, st		Yes 2 No	28f Location	Street an	d Number or Rura	I Boute Number	
Ρi	al or A safter il Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	acci, lactory, office		City or To			r rioute warmber,	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best miner: On the basis o and manner st	of my knowledge, dea f examination and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time	cause(s) , date and	and manner as st d place, and due to	ated. the cause(s)	
	To th Within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Dat	te signed (Month,	Day, Year)	
	/		1	~	ND	D 00	66171		Sen	tenler :	30 2007	
-	2~		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	D		1/1	מחוחח		
×	/		Jessa Edela 31. Date filed (Month, Day, Year)	ian MD &	401 ULO (CURT KD.	KAINDALL	STOWN,	140	21122		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessa Edelman MD 5401 OLD COURT RD. RANDALUSTOWN, MD 21133 State Registrar OCT 0 2 2007											

Registrar DHMH 17 Rev 1/2001 07-07653 John Buettner **Medical Examiner Funeral** Director 28a-f show

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31430 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician. 0030 hrs September 30, 2007 PHILLIP BUETTNER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 11 North Eutaw Street Apartmet 601 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Months Hours Days Min 217-54-1751 Country) Maryland 58 1 X M Yrs Feb. 24, 1949 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 XYes 2 No tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Maryland Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 11 North Eutaw Street 21201 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No Yes 2 X No specify: White If Yes, Give Yee Widowed 4 Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Compl Law Enforcement Policeman 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ella Henry Joseph Buettner Pauline Yupatoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Leroy Buettner / Brother 606 Riley Ct., Apt. D, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, Important: If ite crematory or other place) 2 XCremation 3 Burial Other Specify Hilltop Service Corp. 10-2-07 Towson, Maryland Donation 5 22 Name and Address of Facility McComas Funeral Home, P.A. nature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, 9 Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death i signed by the atte d be detached for u 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) director, Be examiner? Other₄ Hospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes filled in by the funeral 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending within 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. September 30, 2007 30. Name and address of person who completed cause of death (Item 23a) 10 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 0.2

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

12. Was Decedent Ever in U.S. Armed Forces?

Usual Residence of Decedent

10e. Street and Camberra

10b. County

8903 Canbera Drive

Prince George's

10a. State

Director

MD

11. Marital Status

Pages 1 and 2 should be filed within 72 hours after death with the Maryland or items 23a or 28a-f show aminer must be notified at Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ②CM No If Yes, Give Year or Dates:	1 ☐ Yes 2/CXNo	Specify:	, 5.5.,	Specify: I	Black			
eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of workin	g 16t	. Kind of Business	/Industry			
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	cy Computer			:				
To Be C	17. Father's Name (First, Middle, Last) Foster Carl Bro	ooks		18. Mother's Name Esther	(First, Middle, Mai Johnson	den Surname)				
	19a. Informant's Name/Relationship (Type. Print) Jeannette Brooks/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe 8903 Canberra Drive, Clinton, MD20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Townestery, Crematory or other place)									
	20a. Method of Disposition 137 Burial 2 □ Cremation 3 328 4 □ Donation 5 □ Other (Specify)		Location - City or Town, State ittsburgh, PA							
ouce.	22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230									
n	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	th. Do not enter the mode of dyin		respiratory arrest,		Approximate Interval Between Onset and Death			
al er	Immediate Cause (Final disease or condition resulting in death) a. M S W Due to (or as a consequence of): Due to (or as a consequence of):									
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year							
d by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1									
Completed					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of			
Be C	25. Was case referred to medical			26. Place of Death						
To E	examiner? 1 ☐ Yes 2 ☑ No	łospital: 1 ☐ Inpatient 2🔀	ER/Outpatient 3 DOA Oth	er: 4□ Nursing Hon	ne 5 ☐ Residenc	e 6 □Other (Spe	ecify)			
ertification: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1	yat 2 k? Yes 2 □ No	28d. Describe how injury occurred					
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory, office fy)	street, factory, office 28f. Location (\$\frac{\chi}{City}\ or Tow			Street and Number or Rural Route Number, wn, State)			
Medical (owledge, death occurred at the tination and/or investigation, in my o							
Ň	29b. Signature and title of certifier		29c. Licens	e number 06405.	-	P/23/				
	30. Name and address of person who con	mpleted cause of death (Iten	_			11 60 1	* *			

10c. City, Town or Location

Clinton

10f. Zip Code

20735

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Reg. No. 2 []

4c. County of Death

10g. Citizen of What Country?

USA Race - American Indian Black, White, etc.

Prince George's

Birthplace (State or Foreign Country)
 PA

10d. Inside City Limits

1X Yes 2 No

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Adele Bossmar		1- For State Registrar	ite of Maryland		rtment c tificate c		nd Mental F	-	eg. No. 200	7 3 1 4 3	
	Physician/ 1. Decedent's Name (First, Middle,Last) edical Examiner ADELE IRIS					BOSSMAN		2. Date of Dea Month Septembe	oth Day Year er 25, 2007	3. Time of Death 1405 hrs	
		4a. Facility Name (if not institution Greater Baltimore Med	, give street and number)			4b. City, Town, c	r Location of Dear		4c. County of Deat		
Funeral				e (In yrs. la	ıst birthday)	Towson	ar If Under 24Hi	rs. 8. Date of Bir	Baltimore Co		
Director			1M 2XF	6	52 Yr	Months Da		_	Forei		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ition				10d. Inside City Limits	
/land -f show once,	or.		ΓΙMORE	RANI	DALLST	NWC				1 Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What Cou	intry?	
with the is 23a cenotif		9059 MEADOW 11. Marital Status	HEIGHTS ROAD 12. Was Decedent		S. 13. W	2113, as Decedent of H		Specify Yes or No	U.S.A.	rican Indian, Black,	
death or item must b	Funeral	1 Never Married 2 X Mar	rried Armed Forces?	X No		Yes, specify Cuba			White, etc.	mount matern, black,	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by	3 Widowed 4 Divol 15. Decedent's Education (Speci	ced If Yes, Give Year			Yes 2 X No				WHITE	
7 * 7	eted	Elementary/Secondary (0-12)	College (1-4 or 5		during r	nt's Usual Occupa nost of working life	e. DO NOT use re	tired)	16b. Kind of Business.	Kind of Business/Industry	
0036 within jene.	Completed	12			SEC	CRETARY			CONSTRUC	TION	
21215-0036 und be filed within 72 Mental Hygiene. marked other than " c event, the Medical.	Be C	17. Father's Name (First, Middle, L JACK	.ast)	FLC	OMENBAU	JM	18.Mother's Nam	ne (First, Middle, I	Maiden Surname) COPELA	AND	
∑ 교육 및 S	P.	19a. Informant's Name/Relationshi		1					mber, City or Town, State	e, Zip Code)	
m 2 d 2 M	1	MARTIN BOSSMA 20a. Method of Disposition		20h P	lace of Disno	sition (Name of co	metery	ROAD -	RANDALLSTON	NN MD, 21133	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other Spe	3 Removal from Sta	te SHAP	(RETY 29	ONG CONG	. 09/:	30/2007	1	·	
Baltimore permit. Pages I Department of I Important: If injury or other		21. Signature of Funeral Service L			22.	Name and Addres		SOL LEV	INSON & BRO	OS., INC.	
Physician	1	23a Part I Enter the disease or o	omplications that caused to	he death	Do not enter	8900 RE	STERSTON	WN ROAD	- PIKESVILI	E, MD 21208	
/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Complications of diabetes mellitus Due to (or as a consequence of):									
xaminer											
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of)):		-				
1	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	guence of)):						
executed an and al - transit	a EX	- '	d								
	ledic	X UNPENDED	#23a,PII,2	7.perM	E,g873,	11/8/07 T	Γ		5.51		
6876 ertifical ding ph	an/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		2 Fe	etal death 3	Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year	
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unkn	own g Unknown	ime of dea	oth 5 o	ther (Specify)			30		
ires that the d signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
duires t quires t en sign uld be c	ted t	Atherosclerotic ca						04- 144	s 2 No 3 Pro		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed by	pulmonary disease, chronic atrial fibrillation, recurrent urinary 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?									
tal Rec cian: The certificate ector, page	OS e	tract infections 25. Was case referred to medical				26.Place	e of Death (Check	1 Yes	2 No 1 Y	es 2 No	
Vita hysicia this ce	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier		ER/Outpatient		IOther:		Residence 6 Other	r:	
rn of viding Ph. h.: After t	ü	27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Injur (Month, Day,Ye	y ar)	28b. Time of		ry at Work? Yes 2 No	28d. Describe	how injury occurred		
/isior r Attend ter death irector: in by the	ficat	2 Accident Investig	gation 28e Place of Inju	ıry - At hor	me, farm, stre	et, factory, office I		28f. Location (S	Street and Number or Ru	ural Route Number, City	
Div spital o	Certification:	4 Homicide determ						or Town, S	state)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		sician: To the best of my ner: On the basis of exam	_							
To To	₩.	29b. Signature and title of certifier	and manner stated.		<u>. </u>	29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)	
1		Donna mi	Incerti, m.D.			O.C.	M.E.		September 26, 2	2007	
Co O pero		 Name and address of person w Donna M. Vincenti, MD 	no completed cause of de Assistant Medica	,		Penn Street	, Baltimore. M	1D 21201			
	_	31. Date filed (Month, Day, Year)	32 Registrar	s Signature							
Regist	rar	OCT 0 2 7	007 States	· D	A CONTRACTOR OF THE PARTY OF TH						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 0 7

Certificate of Death

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept **Physician** Colder 2007 /Medical 4c County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Lutherville Lollege If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 87 Yrs. 220-03-4701 9/15/1920 Balt., Maryland Director Usual Residence of Deceden with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow The marked other than "neturel" or flems 23a or 28e-f ehov treumstic avent, the Medical Examinat must be notified at Maryland Towson Baltimore 1 ☐ Yes ZXXNo Directo 10g. Citizen of What Country?
United States
Of America 10e. Street and Number 10f. Zip Code 21286 519 1D Epsom Road death v America Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other than "neture!! Any injury or other treumetic averaging injury or other treumetic averaging." 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married White 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otho Scott Colder Catherine Kilmeyer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Scott Colder/ son 8413 Tally Ho Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cometery, crematory or other place)
Dulancy Valley 1 Burial 2 □ Cremation 3 □ Removal from State October 4 ☐ Donation / 5 ☐ Other (Specify) Memorial Gardens 2, 2007 Timonium, Maryland 21. Signatury of Funeral Service License 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner signed by the ettending physicien end d be deteched for use as the buriel-transit certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Heav \$ cete hes been sig , pege 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has 2 10 No 1 ☐ Yes 1 □ Yes 2 □ No I or Attending Physician: efter death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living ۵ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours efter death.

To the Funerei Director: After this c completely filled in by the funeral dir 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 57444 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bux 19099 140 Alexander Chen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rav 6/95

			1- State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of		_	ene 2007	31435
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Isabel K. Cole				2. Date of Death September	^ [□] 28, 2007	3. Time of Death 9:30 A M
	Examir		4a. Facility Name (If not institution, give street and number) Stella Maris			or Location of Death		4c. County of Death Baltin	
	Funeral Director		220-14-0019 1□M 2¬F	90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Cou. Penn	place (State or Foreign ntry) S ylvani a
	Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or Lo	kville				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a- st be notif	Funeral Director	10e. Street and Number 3227 Texas Avenue		10f. Zip Code 21234	4	10g	g. Citizen of What Cou	ntry?
9800	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medical once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+) (Give life. L	dent's Usual Occup kind of work done DO NOT use retire memaker	oation during most of work d)	ing 16	6b. Kind of Business/In	dustry
yland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Robert J. Rinehart			Ida	e (First, Middle, Ma M. Brewer	niden Surname)	
	1 and 2 sho Health and Im 27 is ma		19a. Informant's Name/Relationship (Type. Print) Helen C. Markert - Niece 20a. Method of Disposition		7 Texas	Avenue P	arkville,	City or Town, State, Zip Maryland	21234
Baltimore,	it. Pages introduced introduced intrant: If ite		20a. Metriod of Disposition 1	Parkwood	natory or other place Cemeter Name and Addre	y 10/0	1/2007 P	c.Location - City or To Parkville, Harford R	Maryland
Ba	permi Depa Impor any ir		I Charles of Mines of	Le	onard J.	Ruck, In	c. Balt	imore, Mar	yland 21214 Approximate
	Physician /Medical		23a. Part1. Enter the disester, or complications that aused shock, or heart failure. List only one cause of each lin Immediate Cause (Final disease or condition resulting in death) PNEUM Due to (or as a		5. 410 mode of dyn	ig, outri do cardido	or respiratory arres	,	Interval Between Onset and Death
8760,	iticate be executed by physician and burial-transit and and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
P.O. Box 68	eath certil attending for use a	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome properties the past 12 months? 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	у		23d. Date of deliver	ery Day Year
	requires that een signed b rould be deta	ed by Pł	Part II. Other significant conditions contributing to death bu	t not resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute to t	
Il Records,	law as b	Complet					24a, Was an autopsy performe	prior to co	psy findings available mpletion of cause of
or Vital	Phys r this ral dii	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Inpatier 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	y 28b. Time of		er: 4 Nursing Ho	(Check only one)	ce 6 NOther (Specil	W HOSPICE
Division or	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune	Certification:	2 Accident investigation	ry - At home, farm, stre . (Specify)	M 1□	Yes 2 □ No	28f. Location (Stree Cify or Town, S	et and Number or Run State)	al Route Number,
	the Hospital nin 24 hours a the Funeral npletely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state.	examination and/or inv	n occurred at the til vestigation, in my c	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as se and place, and due to	stated. to the cause(s)
	To the within to the comp	Ž	29b. Signature and tife of certifier		29c. Licens	e number	29d	Date signed (Month,	*
į) Sta	ta	30. Name and address of person who completed cause of de DR. TARIQ MAHMOOD 2300 DUI 31. Date filed (Month, Day, Year) 32. egistra	ANEY VALLE	Y RD. T	IMONIUM,	MD 21093		
	Registr		OCT 0 2 2007 June	r's Signature	all				

SEPTEMBER 28, 2007 9:30 a.m.

ISABEL COLE

State
Registrar

DHMH 17 Rev 1/2001

EASTERN AVENUE BALTHORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN DOYLE

OCT 0 2 2007

31. Date filed (Month, Day, Year)

4940

Registrar's Signature

07-07655 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tanya Elizabeth Dennis State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year September 30, 2007 Tanya Dennis **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Directo 022-72-3480 2 X F Mar 19, М 23 Usual Residence of Decedent 10a. State 10b. County I0c. City, Town or Location Maryland Montgomery Dickerson "natural", or items 23a or 28a-f sho Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shr Director 10e. Street and Number 10f. Zip Code 20520 Mouth of Monocucy Road 20842 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married $_2X$ Yes f Yes, Give Yea Widowed Divorced Yes 2 X No specify: ğ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical 21215-0036 12 Horse Trainer 17. Father's Name (First, Middle, Last) Joanne T. Hoar Robert W. Dennis 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Joanne Dennis/ Mother 142 Valier Avenue, Chicopee, 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Burial 2 Cremation 3 X Removal from State Springfield Crematory Donation 5 Other Specify ignature of Funeral Service Licensee 22. Name and Address of Facility **Physician** failure. List only one cause on each line /Medical Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X AMENDED Item#18, perFH, C872, 10/2/07, WS attending physician or use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy . Was decedent pregnant in the Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an autopsy certificate has performed? ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Hospital: 1 2 V ER/Outpatient 3 Nursing Home 5 this Inpatient 1 V Yes ٩ After t 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 **FOUND** Natural 1 Yes 2 V No death. the f Pending Director: Sep 29, 2007 2 Accident 2302 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Suicide Could not be determined

n/a 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Country) 1984 10d. Inside City Limits Yes 2 X No 10g. Citizen of What Country United States 14. Race - American Indian, Black, White, etc. White Specify 16b. Kind of Business/Industry Equestrian 18.Mother's Name (First Middle Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Massachusetts 01020 20c. Location - City or Town, State Oct 5, 2007 Springfield, MA Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Residence 6 28d. Describe how injury occurred Certification: Driver auto fixed object collision filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Md. 28, Dickerson, Md. the Funeral (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. September 30, 2007 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DOME ORIGINAL

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0100 hrs

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			1 - For State Registrar	State of Ma	ıryland		ırtment of I <i>tificate of</i>				enzé UU/ p. No.	31438
	Physici /Medi		1 Decedent's Name (First, Middle, Li	arton	I	DIK	25			Date of Death Month	Day Yea 21 200	3. Time of Death
	Examir Funeral		5. Social Security Number 6.	SPKINS HO	OSPI (In yrs. las	**	4b. City, Town, of the City, Tow	mac	of Death	Date of Birth (Month, Day,) ine 25,	4c. County of De	eath Sirthplace (State or Foreign Country), 20191a
	Director		Usual Residence of Decedent			Yrs.			μυ	ine 25,	1945 Ge	eorgia
	Aarylan show ed al	ō	10a. State 10b. County GA Bleckley	7	-	Town or Lo :hran	cation					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number			- III GII	10f. Zip Code			100	g. Citizen of What	
	ath wit	ralD	178 East Lakeshor				3101				USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 AN If Yes, Give Year or Dates:	ver in U.S. o	l t	Vas Decedent of he Yes, specify Cub	lispanic Or an, Mexica Specify		/ Yes or No- an, etc.)	Black, Wi	nerican Indian, hite, etc. Thite
<u>5</u>	"natur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	ent's Usual Occup kind of work done OO NOT use retire	ation during mos	st of working	16	6b. Kind of Busines	ss/Industry
21215-0036	d within jiene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5- 4	+)		ner/Oper			I	nsurance	Company
Maryland 2	ould be filed Mental Hygie arked other atic event, L	To Be C	17. Father's Name (First, Middle, Las Obie Carlton Dyke			•			ers Name (F	irst, Middle, Ma	uiden Sumame)	<u> </u>
lary	2 should and Men le marke sumatic		19a. Informant's Name/Relationship								City or Town, State	, Zip Code)
ė, _	1 and Health em 27 other tr		Mary Ann Dykes -	Wife	20b. Plac	ce of Dispos	8 E. Lak		e Dr.		o, GA 31 oc. Location - City	014
ē	Pages nent of I ont: If its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			-	latory or other place 11 Cemet		9/24/		Cochran,	
Baltimore,	permit. Page Department Importent: If any injury or		21. Signature of Funeral Service Lice	end le		22 F 1	Name and Addre ISher Fu 22 W. Dy	ss of Facil neral kes S	Home	hran. G	A 31014	
	Physician /Medical Examiner	9	23a. Pan 1. Enter the disease, or construct, of heart failure. List only limited late flause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to or as a	e. 1000sequel 240 s	1510 nce of):	or the mode of dyin	ng, such as	s cardiac or re	spiratory arres	t,	Approximate Interval Batween Onset and Death 10 VP015
68760,	fficate be executed physician and is the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	conseque		uncer					Mear
	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	2 ☐ Fetal de	eath 3 🗌	Ectopic pregnancy Other (specify)	/			23d. Date of d Month	lelivery Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death but	t not resulti	ing in the un	derlying cause giv	en in Part	l.			to the cause of death? Probably 4 Unknown
Vital Records,	The law requir te has been si age 2 should I	Completed								24a. Was an autopsy performe	prior to	
Vital	Physicien: The la r this certificate hav ral director, page 2	Be	25. Was case referred to medical examiner?	Hamitali			011		e of Death (C	heck only one)	(10)	50 20 10
 	ding Phys h. After this funeral dir); To	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury	28	VOutpatient Bb. Time of	3□ DOA Oth 28c. Injur Wor	4 🗆 N	-		ce 6 Other (Sp injury occurred	pecify)
NO N	ending sath. or: Afte he fune	atlor	1 Natural 5 Pending 2 Accident investigatio		Year)	Injury		k? Yes 2□	No			
Division of	tel or Atti is after de al Directo ed in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined			e, farm, stre	et, factory, office	- 3.11 77	28f.	Location (Stree City or Town, S		Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death as a fire death To the Funeral Director: After this certifies completely filled in by the funeral director; p	Medical (29a. Certifier (Check only one)	nysicien: To the best of niner: On the basis of a and manner state	examination	edge, death n and/or inv	occurred at the tirestigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred a	due to the caus at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1000			29c. Licens	e number			. Date signed (Mo.	
	(30. Name and address of person who	completed cause of de-	ath (Item 2)	3a) (Type F	Print)	-00	0	X	ptembe	r 21,2007
	12		Mottnew Weigh				•	A 30	Minor	e Mor	yland 2	1287
	Sta	to	31. Date filed (Month, Day, Year)	32, Registrar			con					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene U U 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $25^{\text{Day}}, 2007$ Sept **Physician** John L. 12:00 PM Davis /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HEALTH & REHAB WASHINGTON FORT PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 250-28-3996 85 7/6/1922 Director South Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural" or transfed other then "natural" or transfer 10a. State 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
ent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince George's Fort Washington Direct 10e. Street and Number 10g, Citizen of What Country? 502 Bonhill Dr. U.S.A. 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X X Yo Specify: Specify: Black ģ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Board of Education Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Hughie Davis <u> Isola Rowell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Foxworth (Niece) 502 Bonhill Dr. Fort Washington ND 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature of Funeral Service (Corpses permit. Page Depertment of Importent: If eny Injury or once. Lee Crematory 9/28/2007 Clinton, MD Lee Funeral home
Ferry Rd. Clinton, MD / 11.
Approximate Interval Between inset and Death 22. Name and Address of Facility 6633 Old Alex. MD 20735 23a. Part1. Filter the o sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or held (filter). List only one cause on with line. Immedium Cause (Final diseas) or consition **Physician** well /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physicien and hed for use as the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 1 No Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certifice filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place Death Check only one Hospital: 1 Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxima Berwa, M.D. 7700 Old Branch Av Suite ClOl, Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH, C872, 10/30/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Dav 29, 2007 Vincent J. DiCrescenzo /Medical September 12:46 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Gilchrist Center</u> Towson Inder 1 Year Baltimore 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Nur If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Hours Min. Davs 213-16-6 Director 86 September 04, 1921 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a must b 4120 Raleigh Road 21208 United States of America Funeral "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 TYPes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ₹ Divorced Completed item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baker Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Pasquale DiCrescenzo Anna Faraone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Berman (Sister) 4120 Raleigh Road, Pikesville, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 10/06/07 Woodlawn, Maryland 21207 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Libenses MOOSS 8728 Liberty Road, Randallstown, Maryland 21133 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** anso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the s should be detached i ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death/out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death N-Charles St Balto, and Zo 205 -Bm 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 31441

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		20413 Waters Point Lan	T	,		German				Montgomery			
Funeral		Social Security Number 6.	Sex 7	'. Age (In yrs. I	ast birthday)	If Under 1			te of Birth(N		Birthplace (State or		
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13	-	Usual Residence of Decedent 10a. State 10b. County		Inc. City	Town or Location	on					10d. Inside City Limits		
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0036 within 72 hours after death with the Maryland jiene. rer than "natural", or items 23a or 28a-f she Medical Examiner must, be notified at once	_ L	11. Marital Status	12. Was Dece	dent Ever in U		Decedent of	of Hispanic Orig	gin? (Specify Ye , Puerto Rican, e	es or No-		nerican Indian, Black,		
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MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than surmatic event, the Medica	- 4	Judy A. Dalrymple	e / Wife		20413	Water	s Point	Lane,	Germa	intown, M	1D 20874		
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Baltimore, permit. Pages I at Department of He. Important: If tie injury or other tr	1	21. Signature of Funeral S			Robe	ame and Ade	dress of Facility	Funeral I	Home/Ro	ckville, I	inc.		
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	_	Sequentially list conditions, if any, leading to immediate											
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and transit	Exa	events resulting in death) Last	Due to (or as a c	onsequence o	f):								
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M. T. S.	ξ	29b. Signature and title of certifier	and manner sta	itea.		29c. Li	cense number		29	9d. Date signed ((Month, Day, Year)		
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orpero	Ì	30. Name and address of person wh				Donn Ct	not Delti-	oro MD 040	101				
		Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Me	edical Exan istrar's Signaty			eet, Baltim	ore, MD 212	:01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year FILIPIAK 10:44 AM EDWARD SEPTEMBER 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CA "Inder 1 Year If Under 2 "avs Hours Examiner JOHNS HOPKINS HOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 80 215-22-4028 Director March 13,1927 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XYes 2 No Directo Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n 433 Bonsal Street 21224 USA Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 years Welder Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be Stefan Filipiak Josephine Bangor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 item 2 Wife 433 Bonsal Street, Baltimore, Maryland 21224 Rose Filipiak 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
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Important: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State October 4, Sacred Heart of Mary Cem. 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD. 2007 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DUE TO CONDUCTION disease or condition resulting in death) ASYSTOLE 10 MINUTES /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE 10 YEARS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No page 2 s autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl o e) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 3□ DOA 1 Inpatient 2 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 ☐ Accident 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 Yes 2 No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) T2606

State Registrar TIOSPITAL

SEPTEMBER 30

600N.WOLFE STREET, BALTIMIRE, MARYLAND

. 2007

21287

MEDICAL

LAEGER

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS

DOCTOR

HOPKINS

Registrar's Signature

Physician Medical Examiner 23a Part I. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imperial diseases or condition resulting in death) 25a Part I. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of Conservation of the Conservat				Please Type or Print in Black Indelible ink. Ensur		-	•	
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Physician Medical Examinor Physician Medical Examinor Physician Medic	e e	item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. L	ocation - City or	Town, State
Physician Medical Examinor Physician Medical Examinor Physician Medic	E	Page tent c nt: If		1 Ma Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	1-78-	2007 Ba	Himara	Mariland
Physician Medical Examinor Physician Medical Examinor Physician Medic	Ħ	orta					umine.	on Drokitile
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The color Color	П	Dhysisian		Immediate Cause (Final				Onset and Death
Segmentially list conditions, if any, leading to immediate cause. Enter Underlying cause given in Part I. Segmentially list conditions, if any, leading to immediate cause. Enter Underlying cause given in Part I. Segmentially list conditions, if any, leading to immediate cause. Enter Underlying cause given in Part II. Segmentially list conditions, if any, leading to immediate cause. Enter Underlying in death) Last resulting in death but not resulting in the underlying cause given in Part I. Segmentially list conditions. Cause for light resulting in death) Last resulting in death) Last resulting in death) Last resulting in the underlying cause given in Part I. FEMALE: 23b. Was accepted in program of the resulting in the underlying cause given in Part I. 1	Â.				enoca	canom	2	~ 60 days
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State St		i des	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Caro R. Shapita in Harking Bayvan Eartern Ava Balance Months (Item 23a) (Type, Print) State 31. Date filed (Month Day, Year) 32. Registrar's Signature				Do 25	760	9-	210-21	\^7
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State 31. Date filed (M&ath, Day, Year) 32. Registrar's Signature		5		GaraR. Sharita IND Haking BrivE.	w 8	Eartein	DVC. 7	alternous MD
Registrar OCT 0 2 2007 See St. See St.		Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
		Registr	ar	OCT 0 2 2007 Jakes & Brake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marylant? Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MARY FINNEY SEPTEMBER 2007 1:25 A M ☆/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALISTOUN NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**∀**F 181-14-5465 Usual Residence of Decedent 85 Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit fshow r 28a-f show notified at Baltimore Pikesville MD 1 Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 1350 Dudvale 21208 USA Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: 3 ₩Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. "QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) omestic omestic 12 Ith and Mental Hygie 27 Is marked other r traumatic event, tl 17. Father's Name (First, Middle, Laps, 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be atrick eller ပ nna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau once, Pikesville, MD Mill claughter 799 Dharon Urtiz Rd. 20a. Methød of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 1 WBurial 2 □ Cremation 3 □ Removal from State 0 14 4 ☐ Donation 5 ☐ Other (Specify) harles 0 Pikesville, MD 21. Signature of Funeral Service License Greene Funeral 22. Name and Address of Facility Tough Varia lene dall stowi 21133 berty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CANCER NON-SMALL Physician CELL LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in redict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur és a consecuence ut) Examine certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) or Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1□ Yes 2 **□** No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D54357 SEPTEMBER 29 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINCEA TODON HOSPITAL NORTHWEST 5401 OLD COURT ROAD RANDALL STOUN 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar

Funkhouser, Thomas Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Please T	ype or Prin					-		gible.	
		For	State of Ma	aryland				Mental Hy	giene		
		1 - State Registrar			Cer	rtificate of	Death	F	Reg. No2 (<u> 107</u>	3 4 4 6
Physici	an	Decedent's Name (First, Middle, Last)		L. :	Funkho	user, Sr		2. Date of Dea Month	ath Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give s					r Location of Death	9	26	nty of Deat	8:55PM
Examir	er	Franklin Squ	uare Ho	ospi	tal	Rose	dale		Bo	Itin	nore
Funeral Director	2.	5. Social Security Number 6. Sex		e (In f rs. 18 52	ast birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	, Year)	Co	hplace (State or Foreign untry)
		214-44-2367 Usual Residence of Decedent						Aug. 1	1,1945	Wes	st Virginia
arylan show dat	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
the Ma 28a-f	Director	Maryland Balt 10e. Street and Number	imore			10/ 7: 0	Overlea		10 011		1 ∐Yes 2 XNo
with 3a or 1		19 East Overlea	Avenue			10f. Zip Code 21206			10g. Citizen		
death ms 2;	Funeral		12. Was Decedent B	Ever in U.S	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	Unit		rican Indian,
after or ite	/ Fu	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1X Yes 2 □ N If Yes, Give	lo		r Yes, specify Cuba I⊡ Yes 2 ⊠ No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc.
hours tural";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	Viet	tnam						White
be filed within 72 hours after death with the Maryland tall Hygiene. tall Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	,	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of worl	king	16b. Kind o	Business/	Industry
d with giene. er thai	lmo;	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	+)		Truck Di	river		Tru	ckina	
tal Hy	Be C	17. Father's Name (First, Middle, Last)			-		18. Mother's Nam	e (First, Middle,			
ould I	은	Edgar Funkhouser 19a. Informant's Name/Relationship (Type)			1			ysel Ke			
and 2 sh ealth and n 27 is n		Mrs. Bonnie J. Fu					and Number or Ru				
s 1 an f Heal item 2		20a. Method of Disposition		20b. Pl		ast Over] sition (Name of natory or other place		Overle:	20c. Location		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maral Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1½ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State			Cemeters		/2007	Balt	imore	, Maryland
permit. Departn Importa any inju		21. Sonature Funeral e 12 lens		11	22 D1	Name and Addres	ss of Facility Funeral	Home of	Dunda	ll Tr	
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Physician /Medical		disease or condition resulting in death)	Due to (or as a	bel	lan	HEN	Johr	1age			
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h cert ending	M/u	23b. was decedent pregnant	3c. If yes, outcome p 1 ☐ Live birth			Ectopic pregnancy			23d.	Date of deli	very
le law requires that the death certificate has been signed by the attending physyle 2 should be detached for use as the	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)				Month	Day Year
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w req	Completed					-		24a. Was a	an 24	b. Were au	topsy findings available
The la	dmo					·		autop perfor	sy	prior to death? 1 ☐ Yes	completion of cause of
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ding I	ion:	27. Manner of Death 15 Natural 5 ☐ Pending 2 1 Arcident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe h	ow injury occ	curred	
Atten r deat ector: by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ry - At hor	me, farm, stre		100 2010			mber or Ru	ral Route Number,
tal or	Certification:	4 Hornicide	building, etc	. (Specify))			City or Tow	n, State)		
	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at the ting estigation, in my o	ne, date and place, pinion, death occu	and due to the orred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
To the within To the somple	Me	29b. Signature and title of certifier	0/	7/	7	29c. License	e number	- 2	29d. Date sig	ned (Month	n, Day, Year)
4		· flold	(//	//		Da	05442	8	9/7	7/0	タ
8+1		30. Name and address of person who co	mpleted cause of de	ath (Item	23a) (Type, F	Print)	of this	Bull's	Lava "	MI	71921
Sta	te	31. Date filed (Mepth, Day, Yegr) 2007	32. Registra	r's Sigriati	ure Jul	M Jyun	VILVE	MITIIV	we 1	TU	X100/
Registra		UU! U & 2001	of the state of	Continued on	and the second	(Della)					

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			For State Registrar	State o	f Maryland			t of Health a e of Death			giene Reg. No. 2	007	31447
Ì	Physici		1. Decedent's Name (First, Middle, Arnold E. Foels	,						Date of Dea	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,		mber)		4b. City,	Town, or Location		ерсешс	er 30,	nty of Death	6:38 A. [™]
hi.	LAGIIII	-	Shady Grove Adv	entist Ho	spital		Rock	ville			Mont	gomer	У
	Funeral	T		6. Sex 1⊠ M 2 ☐ F	7. Age (In yrs. I		If Under Months	1 Year If Under Days Hours	Min.	Date of Birt (Month, Da	h v. Year)	9. Birth	place (State or Foreign ntry)
Ē	Director		213-42-9498	I MINIZLI	63	Yrs.			Ma	arch 3	, 1944	Germ	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary Fied a	tor	Maryland Montgo	merv	Gait	hersb	ırg						1 K∏Yes 2 □ No
	h the or 28s	irec	10e. Street and Number				10f. Zip	Code			10g. Citizen	of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. htter than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Directo	105 Timberbrook	Lane #303	3		208	378			United	Stat	es
	er dea tems	nne	11. Marital Status	Armed Fo		S. 13.	Was Deced	tent of Hispanic Or cify Cuban, Mexica	igin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Van Ci	2□No ve ates: Vietn	am	1 □ Yes a	2█ No <i>Specify</i> :			Spe		
2-0036	thour atural	ed k	15. Decedent'	s Education	ales. VIECII	16a. Dece	dent's Usua	al Occupation		-	16b. Kind of		
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77	d with giene er tha the I	Completed	12	J Conege (-401 5+)	Maste	er Pri	inter			County	Gove	rnment
g	be file tal Hy d othe	Be (17. Father's Name (First, Middle, L	.ast)				18. Mothe	er's Name <i>(F</i>	irst, Middle,	Maiden Surn	ame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ဥ	Hans Foelster						Johan				
Mar	12 sh h and 7 is rr traur		19a. Informant's Name/Relationsh					(Street and Numb			-		•
	es 1 and 2 of Health fitem 27 i		Carol A. Foelste 20a. Method of Disposition	r / wire	20b. PI			rbrook Ln	Date		20c. Locatio		
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 🏻 Cremation		State	ace of Dispo emetery, crea		ther place) (orium, Inc.	Octobe	r 5,			
	artme ortan injur e.	1	4 Donation 5 Other (Sec. 21. Signature of Funeral Sovice L		PROLIC	-	_	d Address of Facili Pumphrey	2007	1			ryland
ñ	Per Imp any onc		×.2.(=	()	M008								20850-2805
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that controls one cause on e	aused the death							, ,,,,,	Approximate Interval Between
\	Physician		Immediate Cause Final disease or condition		opulmon	arv Di	isease	2					Onset and Death
	/Medical		resulting in death)		or as a consequ								
	Examiner	L	Sequentially list conditions,				Gastr	oesophag	eal ju	ınctio	n	т	nonths
2	lsit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	ience of):							
-()s	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to	or as a consequ	ence of):							
/60,	ate be executed hysician and the burial-transit	ical		d									
á	death certificate e attending physi d for use as the	8											
X Q	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		come pf pregnar		Ectopic pr	egnancy				Date of deliv	
7	the dea y the at iched fo	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of de		Other (sp					Month	Day Year
7.	hat the detack	Phy	Part II. Other significant condition	s contributing to de	eath but not resu	lting in the u	nderlying c	ause given in Part I		23e Did to	hacco use co	ontribute to t	he cause of death?
ďS,	requires that een signed b nould be deta			to continuating to a	at not too	inig iii iiio u	naonying o	adoo givoiriiri dici			res 2 □ No		bably 4 □Unknown
coras,	> 9 70	Completed								24a, Was			
Ď	e la has je 2	duc								autop perfo	rmed?	prior to co death?	opsy findings available ompletion of cause of
<u> </u>	ician; Th certificate ector, pag	BeC	25. Was case referred to medical					26 Place	e of Death (C	1□ Yes		1 ☐ Yes	2 ½ No
>	Physician; this certificatal director,	0	examiner? 1	Hospital: 1X	npatient 2 ☐ E	ER/Outpatier	it 3 □ DO	Other:			lence 6 □0	Other (Speci	fv)
П ОГ	ng Ph fter th neral	ı.	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date (Mon	of Injury	28b. Time o Injury	2	8c. Injury at Work?	280	l. Describe h	now injury occ	urred	,
SION	tendil eath. or; A the fu	Satic	2 ☐ Accident Investiga	ation			М	1 Yes 2	No				
<u> </u>	or At fter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zee. Flace	of injury - At hor ng, etc. (Specify		eet, factory	, office	28f	Location (S City or Ton	Street and Nui vn, State)	mber or Run	al Route Number,
_	pital ours a eral C		29a, Certifier 1 X Certifying	Physician: To the	hest of my know	wledge deat	h occurred	at the time, date as	nd place, and	due to the	nauso(s) and	Managar as a	Note d
	24 hc 24 hc e Fun letely	Medical	(Check only 2 Medical E	xaminer: On the b	asis of examinati ner stated.	ion and/or in	vestigation	in my opinion, dea	ath occurred	at the time,	date and plac	e, and due t	to the cause(s)
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	_			290	. License number	-		29d. Date sig	ned (Month,	Day, Year)
)			· Merale	is Man	L_ 0.	0		D66189			Septem	ber 30	, 2007
	14.		30. Name and address of person w		e of death (Item	23a) (Type,							
	101,		Meenakshi Andre				rove	Rd., Roc	kville	, Mar	yland :	20850	
	Sta		31. Date filed (Month, Day, Year)	2007 32 R	egistrar's Signat	ure	and B						
	Registr	या	OCT 0 2	CUU1 RAIN	grade As		The state of the s						

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this of completely filled in by the funeral directors. Registrar

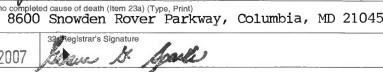
Medical

State

31. Date filed (Month, Day, Year) 02 2007

29b. Signature and title of certifier

30. Name and address of person who co Harry Li M.D.,



m.D.

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 56531

29d. Date signed (Month, Day, Year)

September 29, 2007

			For State Registrar	State of Ma	ryland /		ent of F ate of i		Mental Hy	/giene Reg. No		31449	7
n s	Physici		1. Decedent's Name (First, Middle, La RAYMONO	ast)		-	E	ORD	2. Date of D Month	eath Da	ay Year	3. Time of Death	_
	/Medic		4a. Facility Name (If not institution, gi	ve street and number)		4b. (Location of Dear	09_	2	& 200 c. County of Deat	7	_
	LAGIIII	*	JOHNS HOPKINS	BAYVIEW M	EDKALCE	NA	BAL	TIMORE	CITY	N	/A		
	Funeral Director		219-12-1452	Sex 7. Age	e (In yrs. last b	Yrs. If U	ths Days	If Under 24 Hrs Hours Min	(Month, D	ay, Year	9. Birt Co 925 Mary	hplace (State or Foreign untry) rland	1
	land w t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Location						10d. Inside City Limits	_
	Mary I-f sho fied a	tor	MD N/A		Ba1	timore						1 TYes 2 □ No	
	th the or 28g)irec	10e. Street and Number			101	. Zip Code			10g. Ci	itizen of What Co	untry?	_
	23a ust b	ral	308 Drew Street				21224			USA			
36	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show yo other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			ecedent of H specify Cuba es 🏭 No	ispanic Orlgin? (s an, Mexican, Puer Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, White Specify: White	e, etc.	
P	2 hou	ted	15. Decedent's E	ducation	16	a. Decedent's	Usual Occup	ation		16b. k	Kind of Business/	Industry	_
21215-0036	d within 7 giene. rr than "r the Med	Completed	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO		during most of wo	orking	Beth	lehem S	teel	
Maryland	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Las Raymond I. Ford,	•					me (First, Middle A. Dela				
, Mar	and 2 sho salth and 27 is mi er traumi		19a. Informant's Name/Relationship Amelia Ford- Wif	,	30)8 Drew	Stree	t Baltir			or Town, State, 2 and 2122		
ore	of He		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 [Removal from State	20b. Place cemet	of Disposition ery, crematory	(Name of or other plac	re)	Date	20c. L	ocation - City or	Town, State	
Ē	. Рад tment tant: I		4 ☐ Donation 5 ☐ Other (Special	fy)	0akla	awn Cem			1/2007			Maryland	
Baitimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee							eiler &		
			23a. Park Erter the disease or con	nolications that caused	the death. Do	_					e, MD 21	Approximate	
	Physician /Medical		23a. Pany Enter the disease of cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Λ	ation	pre			,			Interval Between Onset and Death	
Ä	Examiner	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	e of):							_
Ď,	icate be executed physician and s the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence	e of):					_		_
28/60	icate L physic s the b	dical		_ d									_
C. Box 6	death certif e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										
7	that the ed by detac		Part II. Other significant conditions	contributing to death bu	ıt not resultina	in the underlyi	na cause aive	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
ecords,	requires that the een signed by th nould be detache	ted by										obably 4 Unknown	
Hec	The law ate has b	Completed							24a. Wa auto per	s an opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of	
	an: T tificat tor, pa		25. Was case referred to medical	<u> </u>				26 Place of De	1 Yes ath (Check only	one)	o 1 ☐Yes	2 □ No	_
2	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/0	utpatient 3	DOA Oth	DF.			6 ☐Other (Spe	cifv)	_
ion or	ath. ath. r: After th		27. Manner of Death 1	28a. Date of Injur (Month, Day		Time of Injury M	28c. Injur Worl	y at	28d. Describe				
DIVISION	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	. (Specify)				City or To	own, Stat	te)	ural Route Number,	
	ne Hosp 1 24 hou ne Funei bletely fil	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best o miner: On the basis of and manner sta	examination a	ge, death occu ind/or investiga	rred at the tin ation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time	e cause(s e, date ar	s) and manner as nd place, and due	s stated. to the cause(s)	
	To the Comp	ž	29b. Signature and title of certifier				29c. Licenso	e number		29d. Da	ate signed (Mont	h, Day, Year)	
	~ ·		MYVUS, JANK	E LEUNG, ME	EDICAL	DOCTOR	RES	-000		Se	Pt 28 2	2007	
ı	b 1		30. Name and address of person who		_		. 1						
1	-01	•	JANICE LEUNG, 31. Date filed (Month, Day, Year)	71. D: 49	740 E	ASTERI	v Ave	NUE IS	ATIMO	RE	mg 2	1224	_
	Sta Registr		OCT 0 2 20	32 Registra	La	-							
DHI	MH 17 Rev 1/20	001	001 02 20	OI JUNEAU	150	Sparts.	2						_
						ORIGIN	AL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:45PM Marie Glover 2009 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □X Min. 96 219-16-3057 Director 01 15 NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be married once. 10b. County 10c. City, Town or Location 10a. State 10d Inside City Limits 1 ☐Yes 🎖 No Pikesville Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 6 Trotters Court Apt T-3 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes
Yes No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ò Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4or 5+) Self Employed Caterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline Onley Thomas Onlev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trotters Court Apt T-3, Pikesville 1208 James Glover-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 10/2/2007 Laurel, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Sign ture of Funeral Service Ligensee 21215 23a. Pa vi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer late Cause (Final diserse or condition refulting in death) advanced alsbeiner's disease Physician 144ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 HELEN

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tra signed by the a certificate To the Hospital or Attending Physician: this funeral ours after death neral Director: / filled in by the f within 24 hours a

To the Funeral I

completely filled

1

State

29c. License number 0/3657

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) September 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isabelle McGregor, 700 West 40th Street, Baltimore, Md

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

▶ 17 & abelee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year /Medical not institution, give street and number) 4c. County of Death Examiner Location of Death 8. Date of Birth (Month, Day, birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 📉 Months Days Hours Min. Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits must be notified at 1XYes 2 □ No Director MARVLAND 23a or 28a-f 10e. Street and Number Citizen of What Country? Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 2 X No 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. the GRADE Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, <u>tt</u> once, 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>IINNIE</u> Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Signiture of Funeral Service Licensee 2 a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final risease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a After this certificate has been signed funeral director, page 2 should be det Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and License number 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 1/2001

egistrar's Signature

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death September 30, 2007 **Physician** 2:15 A.M Elmore Paul Gross, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Feb. 7, 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1**Ϫ**M 2□F Illinois 82 **Director** 338-18-8744 Feb. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f shov Examiner must be notified at 28a-f shov 1 ☐ Yes 2 X No Maryland | Montgomery Directo Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4209 Anthony Street 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1⊠Yes 2□No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 X No þ Specify: Specify: White 3 Widowed 4 Divorced antal Hygiene.

ed other than "nature c event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Security & Loss Prevention Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H litem 27 is marked oth r other traumatic even Helen F. Gardner Elmore Paul Gross, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20895 4209 Anthony Street, Kensington, Maryland Patsy J. Gross / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Himportant: If ite any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Oct. 1, 2007 | Bethesda, Maryland 21. Signature of Funeral Publice Lio Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00662435 Modiful Cests Dr. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1 ELSAYYAD 97/5
Year 2007 38 Registrar's Signature

9 |30 |07 ZISAM

Elmoke Paul

Registrar DHMH 17 Rev 1/2001

			Please and	Type or Print in Black I In item 4c per doc 9872 State of Maryland? De	ndelible Ink. Ensure A 10-2-07 vt. partment of Health and	All Copies A l Mental Hygic	re Legible.
		_	For State Registrar		ertificate of Death	Reg	No2007 31453
0	Physicia /Medic	an	1. Decedent's Name (First, Middle, La	e Hutchis	on	2. Date of Death	Day 2007 2:45 Am
4	Examin	_	4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death Arme Armel
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthda	Months Days Hours Min.		9. Birthplace (State or Foreign
	ъ		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	the Mary 28a-f sho otified a	ector	MD Anne	Arundel Edger	10f. Zip Code	100	1 ☐ Yes 2 No
	ath with i	Funeral Director		ox ct.	21037		USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	in 72 ho n "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) 16a. De (G)	cedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired)	orking	ib. Kind of Business/Industry
1212	iled with Hygiene ther tha nt, the	Com	17. Father's Name (First, Middle, Las.	2 Dire	tor of Property	me (First, Middle, Ma	raty Maragement Ca
Maryland	ould be f Mental I arked of atic eve	To Be	John A	. Fedor	Ste	phanie	· Baczynski
Mar	nd 2 sho alth and 27 is mu r traum		19a. Informant's Name/Relationship	Type. Print (daughter) 196. Mi	ailing Address (Street and Number or A	Jural Route Number, C	City or Town, State, Zip Gode)
ore,	ages 1 ant of Heart in it is if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	sposition (Name of crematory or other place)	Date 20	c. Location - City or Town, State
Baltimore,	oermit. Pa Departmer Important any Injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	II TO CICO	22. Name and Address of Faith	eral chap	sel + everyation,
	80 E 8 8		23a. Part1. Enter the disease, or con	aplications that caused the ceath. Do not conscause on each line.	enter the mode of dying, such as cardia	mo 21234 or respiratory arrest	t, Approximate Interval Between
	Physician		shock, or heart failure. Ust only Immediate Cause (Final disease or condition resulting in death)	a Esophagus	Cancer		Anset and Death Month
	/Medical Examiner			Due to (or as a conseguence of):			
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x 687	death certificate be attending physic	Medic	IF FEMALE:	200-16-10-10-10-10-10-10-10-10-10-10-10-10-10-			
P.O. Box		Physician/Medical	23b. Was decement pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
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ital F	. @ 0	Be Cor	25. Was case referred to medical		26. Place of De	perform 1⊡ Yes 2 eath <i>(Check ghly one)</i>	•
or V	Phy this	은	examiner? 1 Yes 22 No 27. Wanner of Death	28a. Date of Injury 28b. Tim	e of 28c. Injury at	Home 5 D Residen	ce 6 Other (Specify)
sion	Attending Phr r death. ector: After thi by the funeral	cation	1 Natural 5 □ Pending 2 □ Accident investigatio 3 □ Suicide 6 □ Could not l		M 1 Yes 2 No	206 Location (Ctro	et and Number or Rural Route Number,
Divi	tal or At s after d al Direc ed in by	Certifi	4 Homicide determined	building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) Certifying P 2 Medical Example 1	hysician: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and pla ir investigation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	wen MP	29c. License number	290	d. Date signed (Month, Day, Year)
	15		30. Name and address of person who	completed cause of death (Item 23a) (Ty	pe, Print)	0 FE 3	se(s) and marrier as stated. te and place, and due to the cause(s) d. Date signed (Month, Day, Year) September 27, 2007 Amay 115, MJ 2141
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	190 ST GUTC 1CO	873V	ring wishy with
	Regist	ar	OCT 0 2	2007 Marie &	(10342)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Bertha Marie Harrell 9 2007 1:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1 □ M 12/53 F 76 214-26-6259 11/15/1930 Balt.,Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United states 8820 Walther Blvd. 21234 America
14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sinai Hospital Nursing Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Newton unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Kennedy/ daughter 11 Sparks Farm Road Sparks, Maryland 211**52** 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Dulaney Valley
Memorial gardens 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 2, 2007 21. Signatule of Juneral Service Licensee Péacerul Adres funeral & Cremation Ctr., P.A. 2325 York road Timonium, Maryland 21093 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheirars demonara Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Siture disour 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2 **□ N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident

Examiner the death certificate be executed Records, Vital 0 , O

attending p

Physician/Medical

Completed by

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Medical Certification: To

3 Suicide

4 Homicide

31. Date filed (Month Day, Year)

Physician

/Medical

Examiner

Funeral

Director

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s 1 and 2 should be filed w f Health and Mental Hygier item 27 is marked other th

Department of Health a Important: If item 27 is any Injury or other trainonce.

Physician /Medical

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Director

Funeral

Completed

Be

within 24 hours af

To the Funeral D

completely filled i the Hospital

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Signature

State Registrar

DHMH 17 Rev 1/2001

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year arie /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTI MOR Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 F. 074-68-9695 Hours Month, Day, Year)

031968 Ithaca Director Yrs Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 4746 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Specify: White nit. Pages 1 and 2 should be filed within 72 ho bartment of Health and Mental Hygiene. fortant: If Item 27 is marked other than "natur Injury or other traumatic event, the Medical Injury or other traumatic event, the Medical Injury or other traumatic event. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) earche 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau Men TIMOVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mule Evans Funeral Chapel + Cremation Services 23a. Part1. Enter the disease shock, or heart failure. I mplication that caused he death only one couse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST **Physician** 1811 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dillé to (or as a consequence of): The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2□ No Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and 29d. Date signed/(Month, Day, Year) 30. Name and address REENSPRING 31. Date filed (Month, Day, State Registrar

Registrar

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10	Funeral Director		5. Social Security Number 213-01-6429		7. Age (<i>In yrs. la</i>		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 2	rth ay, Year) 4,1918	9. Birth Cou	place (State or Fore ntry) yland
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	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 3010 Salisbu	ry Avenue			10f. Zip	Code 212	219			of What Cou ed Sta	-
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Division	or Attendafter death. Director: /	ertification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod Zoe. Flace	of injury - At hom ng, etc. (Specify)	ne, farm, stre	eet, factory,	office		28f. Location (City or To	Street and No wn, State)	umber or Rui	al Route Number,

Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No er (Specity) red per or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

29b. Signature and title of certifier whent new mo

OCT 0 2 2007

1)396660

29d. Date signed (Month, Day, Year) Sertember 28, 2007

9:25 P M

9. Birthplace (State or Foreign Country) Maryland

3 Probably 4 Unknown

10d. Inside City Limits 1 ☐Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Durt, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19a,perInf,0872,10/16/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 29, **Physician** 2007 Howard A. Hose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 2258 Druid Park Drive Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1921 West Virginia **Funeral** Months **X**M 2 □ F 236-20-1974 15, Director 86 Jan. Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with r than "natural", or items 23a or the Medical Examiner must be 2258 Druid Park Drive 21211 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? ►XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 💥 No Specify þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mobile Home d 2 should be filed w th and Mental Hygier 7 is marked other th Unknown Construction Worker Manufacturing permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Hose Samuel Hose ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Hose Brother Son 2258 Druid Park Drive, Baltimore MD. 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 □ Donatton 5 □ Other (Specify) Woodlawn Cemetery 10/3/2007 Woodlawn, Maryland 21. Sign nur of Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of): **Physician** 48ARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 2 **X**No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Marsidence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 | Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 24 hours after death. 5 Pending investigation 1XXXIVatural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one)

Box 68760 P.0. Records, Division or Vital

Maryland 21215-0036

Baltimore,

the within 7 2

State Registrar

31. Date filed (Month, Day, Year) OCT 0 2 200

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCTOBER 1, 2007

29d. Date signed (Month, Day, Year)

6565 N CHARLES ST, SMITE 216 BALTIMERE, MD 21204

DENEL

29c. License number

D64395

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23, **Physician** Stephen Thomas Hoffman 2007 21:20 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
111inois **Funeral** Hours 1 3 M 2 □ F Director 512-48-8895 57 May 1, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show items 23a or 28a-f sh ner must be notified Directo 1 ☐Yes 2 XINo Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 enent of Heatth and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 1 and 10 or other traumatic event, the Medical Examiner must be not 19809 Helmond Way 20886 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Frederick Hoffman Marion Sylvester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19809 Helmond Way, Montgomery Village, MD 20886 Vicki Jo Hoffman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State Sept. 29, 2007 Olney, Maryland 4 Donation 5 Dother (Specify) Norbeck Memorial Park 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** CLOSED HEAD disease or condition resulting in death) /Medical Due to (or as a consequence of): mo Examiner Sequentially list conditions, if eny, leading to immediate cause. End of carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1. Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation fell 055 Sept 22 2017 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) HomE Number of Rural Route Number, 4 Homicide omery Village MO 20586 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manual as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

20

Registrar

Stephen

- Offman

8600 OLD GEORGETOWN RD.

BETHESDY, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

SUBURBAN HOSPITAL

32 Registrar's Signature

JAMES MORTON

31. Date filed (Month, Day, Year)

			1 - State of Maryland / Registrar	•	rtment of H tificate of L		ı	Reg. No 200	
	Physici		1. Decedent's Name (First, Middle, Last) GLORIA		HOFFMAN		2. Date of Dea	ath BER 28 200	3. Time of Death 1:30A M
ì	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of De	ath
	Funeral		MARINER HEALTH OF OVERLEA 5. Social Security Number 6. Sex , 7. Age (In yrs. last	birthday)	If Under 1 Year	IMORE If Under 24 Hrs.	8. Date of Birt	h 9. B	N/A irthplace (State or Foreign country)
	Director		216-30-7433 1 1 M 2 M F 72	Yrs.	Months Days	Hours Min.	01/14/1	1935	MD MD
	yland now at		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	ation				10d. Inside City Limits
	e Mar	ector		LTIMO	T -				1 X Yes 2 No
	3a or 2	I Dir	10e. Street and Number 6116 BELAIR ROAD		10f. Zip Code	1206		10g. Citizen of What C	
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No No If Yes, Give Year or Dates:	- 1	/as Decedent of Hi Yes, specify Cuba □ Yes 2 No		pecify Yes or No- o Rican, etc.)	- 14. Race - An Black, Wh	nerican Indian,
2-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	ent's Usual Occupa kind of work done of O NOT use retired	ation furing most of wor	king	16b. Kind of Busines	s/Industry
7	within jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	iire. D	SALES)		ſ	RETAIL
ana	should be filed within 72 nd Mental Hygiene. • marked other than "nat umatic event, <u>the Medic</u>	Be C	17. Father's Name (First, Middle, Last)					Maiden Surname)	F-7846 BI
L y la	should nd Men marke matic	ဥ		HEVIT		JENNI and Number or Ru		ZAL er, City or Town, State	Zip Code)
, M	1 and 2 s Health ar tem 27 is					HOLMES		AK HILL, V	
	Pages 1 nent of H int: if iter iry or oth		1 🔀 Burial 2 □ Cremation 3 □ Removal from State	NSHE"	ition (Name of	e) 00 / 2	Date	20c. Location - City	
	rmit. P partme portani y injun, ce.		4 □ Donation 5 □ Other (Specify) A I I 21. Signature of Funeral Service Licensee	22.	IM CONG. Name and Addres	ss of Facility S		BALTIMORE NSON & BROS	S., INC.
	99 E E 2		23a. Part1. Enter the disease, or complications that caused the death. D	-					Approximate
	Physician /Medicai Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	d	rrest	g, such as cardiac	or respiratory as		Interval Between Onset and Death
orou,	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Insequence or injury that initiated events resulting in death) Last Due to (or as a consequence or injury that initiated events resulting in death) Last						
.O. DOX 001	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physometery filed in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year
cords, r	quires tha n signed uld be del	þ	Part II. Other significant conditions contributing to death but not resulting to death but not resulti	in the un	derlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably Unknown
ב ב	t: The law re icate has bee ; page 2 shor	Completed					24a. Was autor perfo 1∐ Yes	osy prior t	autopsy findings available o completion of cause of ? es No
VII	ysician s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3 DOA Othe	ar.	ith <i>(Check only o</i> tome 5☐ Resid	nne) dence 6 □Other (S	pecify)
VISIOII OF	nding Phy th. : After thi e funeral o	tion: T		b. Time of Injury	28c. Injun Work			how injury occurred	
	ii or Atter after dea i Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	
			1000	-\ (T	6	4443		04-28	-07
	1		30. Name and address of person who completed cause of death (Item 23.	uta	W STA	eet #	f 308,	Ballin	-07 Ove Ma2120
	Sta Registr		31 Qate filed (Month, Day, Year) 32. Registrar's Signature	Coase	e e)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Physician chelle inda Ingram 0.01. /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death 9894 Bayline Circle Baltimore Owing5 If Under 1 Year | Winder Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 97.36.2992 1 □ M 2 X F Hours Min. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Salti more Owings Mill, 10e. Street and Number 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be + Bayline Circle Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ortant; if Item 27 is marked other tha injury or other traumatic event, the I Johns Hophins Univ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental em 27 is marked o David Bagell Potash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bayline Circle Owings mills mo 81117 William Ingram 3altimore, Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition \ 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10.2.2007 Boutimore, mp Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Hreene Juneral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty hoad Mandallstown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encephalopathy **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offithat the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown cate has been signed by a page 2 should be detach contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 wonic Hepatitis 1 Tes 2 No 3 Probably 4 Unknown Completed I Diabetes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No 24a. Was an perforn certificate Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Tyes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 28625 29b. Sic nature and title of certifie

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print) 3100 Saint Paul St., Suite 5, Balhinore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 31462 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPTEMBER 28 HARLES 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs. 91 June21,1916 Maryland 215-22-7502 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-1 show treumatic event, the Medical Examinar must be notified at 1 TYes 2 No Md. n/a Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 South Curley Street 21224 U.S.A. Funeral permit. Pages 1 end 2 should be filed within 72 hours effer deat Depertment of Heellth and Mental Hygiene. Important: if flem 27 le marked other than "---" eny injury or other traums." 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th <u>Sanitation Worker</u> City of Baltimore 18. Mother's Name (First, Middle, Maiden Sumame) (unk) 17. Father's Name (First, Middle, Last) Be Joseph Impallaria ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anita Impallaria (daughter) 7 South Curley St. Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 10-2-2007 Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lice Robert 1201 Dundalk Ave. Baltimore, Md. 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PNEUMONIA 4 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YSTEMIC INFLAMMATORY RESPONSE SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 🗌 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospite 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 SEPTEMBER 28, 2007 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 KKISTI V MERELLE 31. Date liled (Month, Day, Year) OCT 0 2 32. Resistrar's Signature State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Marjorie W. Irvine Sept. 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12818 Eastern Avenue Chase Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 J 236-48-4010 73 Director April 14,1934 WVA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Chase 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12818 Eastern Avenue 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes Ž No Specify: þ 3 Midowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Lockeed Elementary/Secondary (0-12) College (1-4or 5+) Secretary Martins 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfreda Tebay Burton R. Willey Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Gilliam /daughter 12818 Eastern Avenue Baltimore MD 21220 20b. Place of Disposition (Name of cemetary, crematory or other place)

Bayview Crematory 10/2/07 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Avenue Balto. MD Halut Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEART Immediate Cause (Final DISEASE ATHEROSCLEROTI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Diserto (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MALABSORTION 1 Yes 2 No 3 Probably 4 Unknown Completed MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 20 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို _ 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Manth, Day, Year) 29b. Signature and title of certifier D 4000 8 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 FRANKLIN SQUARE DR. BALTIMORE, MD. PARSHALL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 0 2 2007 Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

attending physician and for use as the bunal-trar rector, page 2 s this

Physician/Medical by Completed Be Certification: To

atheroxeleratic Coronary antery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 12/10 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1840 PM

Birthplace (State or Foreign Country)
 MD

10d. Inside City Limits

1 ☐ Yes 2 No

2007

USA

Specify:

14. Race - American Indian.

UNOBTAINABLE

September 26,2007

WHITE

Black, White, etc.

Registrar

24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christine Brand, MD

OCT 0 2 2007

31. Date filed (Month, Day, Year)

5401

32. Registrar's Signature

D0057634

Old Court Road Randallstown, Maryland 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPT. 26,2007 1:00 pm MARCELLA ELIZABETH KLINGENHOFER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1906 MARSDALE ROAD DUNDALK BALTIMORE 8. Date of Birth (Month, Day, Year) JULY 7, 1949 If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 1 F MARYLAND 216-58-0323 58 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No Director BALTIMORE MD DUNDALK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1906 MARSDALE ROAD Funeral 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 12 HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DIETER ILLEAN SALVATORE GANGI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 MARSDALE ROAD, DUNDALK, MD. 21222 RICHARD KLINGENHOFER/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any Injury or ot once. 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 10/1/07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses ZEILER INC. FUNERAL HOME CONKLING STREET, BALTO., MD. 21224 700 S. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of) **Examiner** ea Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 입 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Tes

The law requires that the death certificate be execute physician and is the burial-trans Records, P.O. Box 68760, attending p nse ed by the a signed to certificate has been si rector, page 2 should Division or Vital Hospital or Attending Physician; funeral director. this After 124 hours after death.

• Funeral Director:

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Medical

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item 27

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5 ☐ Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

31. Date filed (Month, Day,

(Check only one)

30. Name and address of be

Year.

2007

29b. Signature

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PHINCHAN

and manner stated.

DHMH 17 Rev 1/2001

within 2

29c. License number

29d. Date signed (Month, Day, Year)

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220	permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tiern 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ		ried 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 22 1 If Yes, Give Year or Dates:	No	1	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		Black, White			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Q Month Physician Day Eugene Walter Kroll, Sr. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AG NES HOSPITAL 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours 10/12/1919 Director 395**-**12-3865 Wisconsin Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits TIS 23a or 28a-f show MD Baltimore Director Lansdowne 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 4th Ave 21227 Funeral United States 7 Is marked other than "natural", or Items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? T 77 1 1 11. Marital Status 14. Race - American Indian. 1 XYes 2 No WW11
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify. Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trailmetic. Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier U.S.Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Alfred Kroll Elsie Schoults 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosanna B. Kroll / daughter 307 4th Ave Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/28/2007 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Stylice Licens 2719 Hammonds Ferry Rd Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAILURE Jn Known /Medical Examiner ETAJTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NEUMONI ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performed? Yes 2 No Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division or funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) SEPT 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **ELLENNE** NGOUNGHA AVENUE BALTIMORE, MD 21229. 900 CATON 32 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per inf 9872 10-9-07 vt.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			Cer	tificate of	Death		Reg. No.	2007	31468
	Physici	an	1. Decedent's Name (First, Middle, La	•					2. Date of D Month	Day		3. Time of Death
	Physici /Medic		John R. Kohlhafer						Septembe			1:15 A. M
	Examin	er	4a. Facility Name (If not institution, give	re street and number)			4b. City, Town, o Bethesda	r Location of Deat	th		County of Deatl	
		*	Suburban Hospital 5. Social Security Number 6.5	Sex 7. Age	a (In ure	last birthday)	If Under 1 Year		8 Date of B			pplace (State or Foreign
	Funeral Director			1 M 2 □ F	83		Months Days	Hours Min.		, 192	24 Mary	untry)
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary Fish	to	Maryland Montgom	erv	Cab	in Johr	1					1 ☐ Yes 2 No
	or 28g	Director	10e. Street and Number	.			10f. Zip Code			10g. Cit	izen of What Co	untry?
	th wit 23a c 1st be	alD	6508 75th Street				20818			Unit	ed State	es
	r dea	Funeral	11. Marital Status	12, Was Decedent E Armed Forces?		S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note of to Rican, etc.)	10-	 Race - Amer Black, White 	
Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparament of Health and Mental Hygiene. Important: If the Mental Hygiene. Important: If the Mental Hygiene any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 ☐ N If Yes, Give Year or Dates: ¶	MMII 10		☐ Yes 2☑ No					White
5-6	72 h "natu	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation <i>during m</i> os <i>t</i> of wo	orking	16b. K	ind of Business/I	ndustry
121	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Machi		2)		Fed	eral Gov	vernment
2	Hygi Hygi Sther	Ü	17. Father's Name (First, Middle, Las.	t)				18. Mother's Na	me (First, Midd	e, Maiden	Surname)	
ne de	ld be lental ked c	To Be	William H. Kohlha	fer				Emma Lol	noefer			
VIE	shou and M mar	-	19a. Informant's Name/Relationship	(Type. Print)			g Address (Street					
Ž	and 2 salth a 27 ls		Frances E. Kohlha	fer / Wife			75th Stre		in John	-		
or o	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. P	lace of Dispo- emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State
į	Pag ment ant: I		4 □ Donation 5 □ Other (Speci		Park		orial Park		2, 2007			Maryland
Balt +	permit. Depart Import any Inj once.		21. Signature of Funeral Service Live)	м008	Rot	Name and Addre	phrey Fund	eral Home	/Rocks	ville, Inc	20850 – 2805
	7 0		23a. Part1. Inter the disease, or con shock, or heart allure. List only								iie, iii	
	Dharafalan		shock, or heart allure. List only Immediate Cause (Final disease or condition									Approximate Interval Between Onset and Death 2 months
	Physician /Medical		disease or condition resulting in death)	a. Lymphom Due to (or as		uence of):			-			2 110110110
	Examiner			h								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):						
الع	rifiicate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
115A	e exe		resulting in death) Last	Due to (or as	a consequ	uence of):						
5,2	ate b	Medical		d								
	sertific ding p		IF FEMALE:	23c. If yes, outcome	nf pregna	incv					Old Date of dell	
7.0 F	w requires that the death ce been signed by the attendi	Physician/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗆 Feta	Ideath 3	Ectopic pregnancy Other (specify)	1			23d. Date of deli Month	Day Year
200	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or a	ou o _	Ciliot (apociny) _					
800	requires that the een signed by the nould be detached	y Pr	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
tal Becords	quires n sign	d by							1	Yes 2	Mino 3 □ Pr	obably 4 ☐Unknown
Ø: 50 E	law re	olete							24a. Wa		24b. Were au	topsy findings available
2 A	sician: The lav certificate has rector, page 2	Completed							pei 1□ Yes	opsy formed? 2⊠No	death?	2 □ No
1/2 Itali	lan: ortifica	BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
125	Physician: r this certificaral director, i	ToE	1 Yes 2 No	Hospital: 1 🔀 Inpatie	nt 2 🗆	ER/Outpatien		4 Li Nui Siriy	Home 5□Re	sidence	6 □Other (Spec	cify)
1	iling Phys I. After this funeral di		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry / Year)	28b. Time of Injury	Wor		28d. Describ	how inju	ry occurred	
Sis	Attending r death. ector: After oy the funer	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No	006 1	(04	-d Moretana - D	and Davids Alicentes
2	or At	ırtifi	4 ☐ Homicide determined		c. (Specify	y)	eet, factory, office		City or T	own, State	e)	ıral Route Number,
1	Hospital 24 hours a Funeral	S	29a. Certifier 1 ☑ Certifying P	hysician: To the best of	of my kno	wledge, death	occurred at the ti	me, date and place	e, and due to th	e cause(s	and manner as	stated.
\$	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification:		miner: On the basis of and manner sta	examina							
	To the within 2 To the comple:	Me	29b. Signature and title of certifier			-	29c. Licens	e number		29d. Da	te signed (Monta	h, Day, Year)
			Helinalia	m			D000	66003	3	sept	ember	28,2007
	621		30. Name and address of person who	completed cause of de			Print)					•
	331,		Helena Kassahun,				etown Ro	ad, Beth	esda, M	ary1a	and 2081	4
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	Se.3					
	Registr	ar	OCT 0 2 20	Ul Add Brien	1 15	A STATE OF THE PARTY OF THE PAR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year DBIT AM Physician 09 Tenm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VARChAB+ Extended CARE Daltimore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⊠**M 2□F 030- 20- 3873 Oct 25, 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show amortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No BAltinore **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 U.5A leasmut Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: white þ 3 NWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. GOVERMENT Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 3 274 19a. Informant's Name/Relationship (Type. Print) HASKELL Nephew 284 TOLN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Cen. 10-2 -2007 Balto Marylanis 5 ☐ Other (Specify) 4 Donation 21. Signature o uneral Service Licensee (Lors CONKling 24 r complications that caused the death. Do not enter the mode of dying, such as cardiac or regiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the discas / shock, or heart fail re. Li Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a detached f 9 ☐ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 400 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Hursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 ☐ M this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation I hours after death. uneral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 047804 09128/207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) od Raven

State Registrar

31. Date filed (Month, Day,

Year)

0 2

DHMH 17 Rev 1/2001

3900

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				nd / Depa	artment of Health and Martificate of Death	lental Hygi	ene 007 31470	
	Physici		1. Decedent's Name (First, Middle, Last) Charles L. Kirby Jr	•		2. Date of Death Month Septembe	2007 3. Time of Death 8:09 p ^M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) National Lutheran Home		4b. City, Town, or Location of Death Rockville	•	4c. County of Death Montgomery	
	Funeral Director		221-01-7695 1⊠M 2□F 91	s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, March 28	9. Birthplace (State or Foreign Country) DE	
	Maryland I-1 show	tor	Usual Residence of Decedent 10a, State 10b, County 10c. (NY Oswego	City, Town or Lo	cation Oswego	10d. Inside City Limits 1 12 Yes 2 ☐ No		
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 4 Burkle Street, Apartment 10	00	10f. Zip Code 13126	1	og. Citizen of What Country? USA	
980	ages 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, Its Medical Examiner must be notified at	Ď	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Amed Forces? 1 ☑ Yes 2 □ No Yes 2 □ No Yes are or Dates.	U.S. 13. Y	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	l within 72 ho iene. r than "natur I'le Medicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 2	(Give	tent's Usual Occupation kind of work done during most of work DO NOT use retired) ACCOUNTANT	ing	6b. Kind of Business/Industry Accounting	
and 2	id be filed ental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles L. Kirby Sr.		18. Mother's Name Lydia		faiden Sumame)	
	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type, Print) Chris Kirby / Daughter		ng Address (Street and Number or Rura Highway 21 S. E.			
Baltimore,	permit. Peges 1 and 2 Department of Health a important: If item 27 is any injury or other tra ance.		1 FRusial 2 Committee 2 FRomough from State	. Place of Dispo cemetery, crer Rural Ce	natory or other place)		coc. Location - City or Town, Slate Cown Of Oswego, NY	
Balti	permit. Pe Departmen important: any injury once.		21. Signature of Funeral Service Licensee	L V 15	Name and Address of Facility Narles L. Stevens 101 Fast Fort Aven	ue, Balt	imore, MD 21230	
760,	Physician //Medical Examiner but situe province and situe province at the partial strains in the partial strains i	icai Examiner	23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the co	Stage equence of):	demertia		Approximate Interval Between Onset and Death	
P.O. Box 68	The law requires that the death certificate is the has been signed by the ettending physionege 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, oulcome of pregular to the pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
	puires that n signed b	þ	Part II. Other significant conditions contributing to death but not re	esulling in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death? s 2 1 10 3 17 Probably 4 10 Unknown	
Il Records,		Completed	renal failure, a	cute		24a. Was an autopsy perform	prior to completion of cause of	
Vital	Physicien: The ribis certificate hiral director, pege	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpalient 2		Othor	h (Check only one		
ō	g Physie this seral di	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatier 28b. Time o Injury	11 3 DOA 4 Nursing Ac	28d. Describe ho	nce 6 □Other (Specify) w injury occurred	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	1 PNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str	M 1 Yes 2 No	28f. Location (Street and Number or Rural Roy City or Town, State)		
J	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my leading the control of the basis of examiner: On the basis of examiner and manner stated.					
	To the To the comp	Me	29b. Signature and title of certifier W. Karesh		D21726		ed. Date signed (Month, Day, Year)	
i	TO			rs Driv	Print) re, Rockville, MD	20850		
	Sta Registi		31. Date filed (Month, Day, Year) 32 Segistrar's Sig	gnature	ask)			

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Funeral

Director

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32 Strar's Signature

OW. US MILLS, MP 21117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland		rtment of H		-	giene Reg. No.2 N N 7	31472
_			Registrar 1. Decedent's Name (First, Middle, Last)		061	inicate of i	Jean	2. Date of Dea		3. Time of Death
	Physicia		Mary Idalene Lyngen					Month Octobel	Day Year 01,2007	6:15 A. M
	/Medic Examin	149	4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of Death	1000000	4c. County of Dea	
	LAGIIII		614 Goucher Ave.				herville		Baltimor	e County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la 4 2 🖾 F 9 1	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 24	h 9. Bir y, Year) C	thplace (State or Foreign ountry)
	Director		216-01-9936	91	115.			May 24	,1916 HOC	pers Is.,MD.
pue	ow at		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
N C	a-f sh	햐	Maryland Baltimore	County Lu	itherv:	ille				1 □Yes 24 No
the the	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
4	23a	ral	614 Goucher Ave.		140.1		L093	seift. Van ar Na	U.S.	
35 affer de	z stoud be free wruin / z nous arest beart with the maryano, and Mental Hygiene. I am Marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:		ryas Decedent of H f Yes, specify Cuba I □ Yes 2 □ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
1215-0036	atural ral Ex	ted t	15. Decedent's Educa	tion	16a. Deced	lent's Usual Occup	oation	ring	16b. Kind of Business	s/Industry
נו 1	an "n Medi	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+) N/a			during most of work d)	ang		
7	ygien ygien erth:	် ပ		n/a	Н	ome Maker		a (Final Adiable	Own H	ome
ביו ביו	tal Hi	Be	17. Father's Name (First, Middle, Last) Herbert Calvert Tyle	er			Nina Geri	,	Maiden Surname)	
S	narke	٩	19a Informant's Name/Relationship (Type		19h Mailir	ng Address (Street			er, City or Town, State,	Zip Code)
Maryland 2	th and		Mr. Wayne Morris Ly.		1	Goucher A			le, Maryland	
ရာ နိ	Heal Heal tem 2		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other place		Date	20c. Location - City o	r Town, State
פֿ ב	nt: If i		1 Burial 2 □ Cremation 3 □ Read 4 □ Donation 5 □ Other (Specify)	moval from State Dul	aney v	Valley Me	em. Oct.(05,2007	Timonium,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		21. Signature of Funeral Service Licenses	-gair, e	7. P	Name and Addr 2325 York	Trernative Road	res Fune Lmonium,	eral&Cremat Maryland	ion ₉ Gtr.,P.A.
	-		23a. Fa 1. Enty the diler se, or complice	ati v that caused the death	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	Caronic.	Rona		ilung			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):					
	Examiner	L	Sequentially list conditions, b.	ASCVP Due to (or as a consequ	iongo of\:					-
13	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ience or).					
	xecur al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	Ine law requires that the death certificate be executed attending bhysician and bage 2 should be detached for use as the burial-transit	dical E	L _d .						1.77	
8	nillicat ng phy as th	Medi	IE ECNAL C							
Вох	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pregna 1□Live birth 2□ Fetal	death 3[⊒Ectopic pregnanc	y .		23d. Date of d Month	elivery Day Year
	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify) _				
л О	mar m ed by detacl		Part II. Other significant conditions conti	ributing to death but not resu	alting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds,	signe signe d be	d by	CORONARY AR	TERY DISER	SE			1 🗆	Yes 2 No 3 □ I	Probably 4 □Unknown
Vital Records,	e law requires that the d has been signed by the je 2 should be detached	Completed by	PERIPHERAL VI	ASCULAR DIS	GASE	-		24a. Was		autopsy findings available
8	e has	duc	JENNAEIAIO NI	10 (0 0) 1 (1) (1)				auto perfe 1□ Yes	prior to primed? death? 2 X No 1 ☐ Ye	
<u>g</u>	an; l rtificat tor, pa	Be C	25. Was case referred to medical				26. Place of Dea			
>	nysici iis cel direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	ome 5 Res	idence 6 □Other (Sp	pecify)
0	ng Pr	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurred	
SIO	tendi eath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	OOf Location	Street and Number or	Puni Pouto Number
Division or	or At after d Direc in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		leet, lactory, office		City or To	wn, State)	Turar rioute rumber,
_	spital ours a neral filled		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge, deat	h occurred at the t	ime, date and place	and due to the	e cause(s) and manner	as stated.
-	lo the hospital of Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		er: On the basis of examina and manner stated.						
-	vithin To th comp	Me	29b. Signature and title of certifier)		29c. Licen			29d. Date signed (Mo	
			1 Spelling	wo		D2	18987		10/2/20	のア
	Ĺ		30. Name and address of person who con					/ A	410 0100	
4	(V)		31. Date filed (Month; Day, Year)	32 Registrar's Signa		RAVEN B	LVD BI	4010.	MD 2123	7
	Sta Regist	ate rar			1					
			OCT 0 2 2007	1730.4 /3	S. Carlo	ASS				

DHMH 17 Rev 1/2001

07-07592 Chris Lang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Cert	tificate of D	Death		Re	g. No. 201	01 0141			
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Deat	h	3. Time of Death 0949 hrs			
Medical Examin		Chris	Laı		City Town o	r Location of Dea	Month Septembe	r 27, 2007 4c. County of De				
/	ľ	4a. Facility Name (if not institution, give 2418 Lincoln Avenue	street and number)		Sparrows F		201	Baltimore C				
Funeral	- 1	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Yes			h(MM/DD/YYYY) 9.	Birthplace (State or eign			
Director		212–90–6016	и 2 <u>_</u> F 30	O Yrs.	Months Day	ys Hours M	June 2	7,1977	Country) Maryland			
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits			
* *	. 1	Maryland Baltimo	ore	Sparro	ws Poi	nt			1 Yes 2 X No			
Maryland 28a-f show	Director	10e. Street and Number		1	10f. Zip Code	_	1	og. Citizen of What C	ountry?			
ith the Maryland 23a or 28a-f sho	₫	2418 Lincoln Avenu			212			USA				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	~ I	11. Marital Status 1 XNever Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was I If Yes	Decedent of H , specify Cuba	ispanic Origin? (in, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - An White, etc	nerican Indian, Black, :.			
ter de:			1 Yes 2 X No	1 Y	es 2 X N	o specify:		Specify: W	hite			
ours af atural	핡	15. Decedent's Education (Specify onl	y highest grade completed)	16a. Decedent's		ation (Give kind of		16b. Kind of Busine	ss/Industry			
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examine	Completed	Elementary/Secondary (0-12) 11 years	College (1-4 or 5+)	Labo	-		,	Construc	tion			
5-0036 led within 7. Tygiene. other than	탉	17. Father's Name (First, Middle, Last)		Labo	Ter	18.Mother's Na	me (First, Middle, I	1				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	a	Glen Lang					anie Prod	-				
D 21 should and Me	H- (1)	19a. Informant's Name/Relationship (Ty Stephanie Allman	pe, Print) mother					nber, City or Town, S cerstown,	1.0			
M 2 alth all 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2	- 14	20a. Method of Disposition	20b. F	Place of Disposition	on (Name of c	emetery,	Date	20c. Location - City				
Baltimore, permit. Pages I an Department of He Important: If ite		1 XBurial 2 Cremation 3		rematory or other k. Lawn C			ctober , 2007	Dundalk,	Maryland			
Baltimo permit. Page Department o Important: injury or out	4	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	ee	22. Nar	me and Addres							
		7110 Sollers Point Road, Dundalk, MD. 21222										
Physician /Medical	- 1	23. F. rt I. Enter the disease, or conf. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approxima Between C. De.										
taminer		Immediate Cause (Final disease or condition resulting in death)	ue to (or as a consequence of		огрише	HILOXICA	ICTOH					
		Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of	·\·								
	.ΕΙ	source Enter Underlying Course										
ted 1 Insit	Exa	events resulting in death) Last d.	due to (or as a consequence of	i):								
760, cate be executed physician and he burial - transit	Medical	X UNPENDED	AMENDED #23a,27,28a-f, p	erME 0874	12/3/0	7 TT						
760, icate by physic the bur	ĕ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy				23d. Date of del Month	very Day Year			
Box 687 e death certifice the attending p ed for use as th	ician	past 12 months?	1 Live birth 4 Pregnant at time of de		I death 3 er (Specify)	Ectopic pre	griancy	World	Day Ica			
BO:	Physician/	1 Yes 2 No 9 Unknown	9 Unknown	14: - : - 46	dadi iaa aaya	aiuna in Dart I	23e Did t	ohacco use contribut	e to the cause of death?			
, P.O.	<u>۾</u>	Part II. Other significant conditions	contributing to death but not re	esulting in the uni	denying cause	e given in Pait i.			Probably 4 🗹 Unknown			
w requires to be signal when the signal was been signal when the signal was a signal with the signal was a si	Completed						24a. Was		e autopsy findings available to completion of cause of			
e law i	<u>d</u>							ormed? deat				
Vital Rec ysician: The l his certificate h	Be	25. Was case referred to medical			26.Pla	ce of Death (Che	eck only one)					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the flueral director, page 2 should be	ၟႍႃ	1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient			ursing Home 5	Residence 6 🗸 0	Other: Scene			
n of viding Ph.	<u>:</u>	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj	` ₁ _	njury at Work? Yes 2 X No		now injury occurred				
r Atter r Atter er deat irector n by th	ficat	2 Accident Investigation	28e Place of Injury - At he		am [28f. Location		r Rural Route Number, City			
Div pital o purs aft ceral Di	Certification:	3 Suicide 6 X Could not be determined (Specify) found at home or Town, State) (Specify) found at home 2418 Lincoln Ave. Spare										
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier (Check only 1 Certifying Physicial Cone) Medical Examiner	an: To the best of my knowled On the basis of examination a	ge, death occurre	ed at the time,	date and place,	and due to the cau	se(s) and manner as and place, and due	stated. to the cause(s)			
To the comp	Medical	29b. Signature and title of certifier	and manner stated.			nse number			(Month, Day, Year)			
	-		Dincenti, miD			C.M.E.		September 2	8, 2007			
	+	30. Name and address of person who o			1			<u> </u>				
			Assistant Medical Exam	-	Penn Stree	et, Baltimore	, MD 21201					
St Regist	ate rar											

			For State	State of M	aryland /		ment of H		nd Me	ental Hyg	giene Reg. No. 2	007	31474
			Registrar 1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath		3. Time of Death
	Physici			DWARD	LUCAS	SR				Month Septemb	Day	Year 2007	9:50 a ^M
1	/Medio		4a. Facility Name (If not institution, give				b. City, Town, or	r Location of		осресии		unty of Death	7.30 a
j.	Examir	ei					ABERD	EEN			н	ARFORD	CO.
-	Funeral		5. Social Security Number 6. 5		ge (In yrs. last t		Under 1 Year	If Under 2 Hours		8. Date of Birt (Month, Day	h		place (State or Foreign
	Director		230-38-5183	MCXM 2□F	75	Yrs.	lonths Days	nours	Min.	DEC. 2			GINIA
	D.		Usual Residence of Decedent		140- Oit T-							1.	10d. Inside City Limits
	ırylar show		10a. State 10b. County		10c. City, To	wn or Locat	Off						1 ☐ Yes 2X No
	e Ma Ba-f s	cto	MARYLAND HARFOR	D CO			DEEN					(11/1-110-11	
	or 2	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	ntry?
	ath w	ra	601 CORNELL ST			140 14/-	2100		:-2 /C	if . Ven er Ne		S.A. Race - Americ	can Indian
	er de item	Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married	12. Was Decedent Armed Forces 1 Yes 2	?	If Y	s Decedent of H es, specify Cuba	an, Mexican,	Puerto R	Rican, etc.)	. 13.	Black, White,	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	110	1 🗆	Yes XX No	Specify:			Sp	ecify: BLA	CK
8	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examlner must be notified at	ed	15. Decedent's E	ducation	16		t's Usual Occup				16b. Kind	of Business/in	dustry
21215-0036	in 72 n "na Medic	Completed	(Specify only highest grant (0-12)	ade completed) College (1-4or	5+)	(Give kin life. DO	d of work done o NOT use retired	during most d)	of workin	g			
212	y with	mo;	6th grade	- College (1 10)	0.7	CONST	RUCTION	@ FR	ITOL	AY	PR	IVATE	
פ	al Hygothe other	Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name	(First, Middle,	Maiden Su	rname)	
<u>a</u>	ould be filed v Mental Hygie arked other I	To	WILLIE LUCAS					ANN	A LUC	CAS			
ar	and and s m		19a. Informant's Name/Relationship	Type. Print)	19	9b. Mailing A	Address (Street a	and Number	r or Rural	Route Number	er, City or To	own, State, Zip	Code)
≥	1 and 2 Health em 27 i		George E. Lucas	Jr./Son			weetby	Drive					
ore	of Heritan		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐	Removal from State			on (Name of ory or other plac	ce)	Da	ate	20c. Locat	ion - City or To	own, State
<u>Ĕ</u>	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Speci			CREM	IATORY	1	0-01-	-07	BALTI	MORE,	MARYLAND
Baltimore, Maryland	permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other		21. Signature of Funeral Service Lice	nsee		WM		COMM	CTINU				FORD, P.A.
_	<u>00 = 80</u>		23a. Part1. Enter the disease, or con				S PHIL					21001	Approximate
Sept.	Physician /Medical Examiner	ir	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ather	ine. Scler s a consequence bete s a consequence	e of):						se	Interval Between Onset and Death
8760, <	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequenc								
P.O. Box 6	eath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2 ☐ Fetal dea at time of death		topic pregnancy	/			23d	. Date of deliv Month	ery Day Year
Records, P	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	by	Part II. Other significant conditions End Stage	contributing to death	1 1.	in the unde		en in Part I.		23e. Did to		/	the cause of death? bably 4 Unknown
ပ္သ	s bee	Completed	Hypertensi	m						24a. Was		4b. Were auto	opsy findings available
Ä	The la	mo	Anemia	_						autor perfo 1⊟ Yes	rmed?	death?	ompletion of cause of
Vita		Be C	25. Was case referred to medical	_				26. Place	of Death	(Check only o			
>	ysici lis cel direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 ER/0	Dutpatient	3 DOA Oth	er: 4 🗆 Nur	sing Hom	ne 512 Resid	dence 6	Other (Speci	fy)
0	ng Ph Iter th		27. Manner of Death 1 Patural 5 Pending	28a. Date of Inj (Month, D		. Time of Injury	28c. Injur Wor	y at k?	2	8d. Describe l	now injury o	ccurred	
<u>Ö</u>	endir eath. or: Ai	atic	2 Accident investigation	n				Yes 2□N	10				
Division or	or Att ter de virect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of it	ijury - At home, etc. <i>(Specify)</i>	farm, street	, factory, office		2	8f. Location (8 City or Tox		lumber or Run	al Route Number,
	ital curs af												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical		nysician: To the besing miner: On the basis	of examination								
	thin 2 the the mple	Med	29b. Signature and title of certifier	and manner s	1		29c. Licens	e number			29d. Date s	igned (Month,	Day, Year)
1	F 3 F 8		1 2/2000	, -		mD	9	0041	90	7	Sept	. 28	2007
			30. Name and address of person yind	completed cause of	death (Item 22)) (Type Pri	nt)	- 0			7'	//	/ /
	6		Hyung Lim		Upper	Ches	apeake	. Driv	e,	BelA	ir, i	MD.	, 2007 21014
	Sta	te	31. Date filed (Month, Day, Year)	/ -	trar's Signature	4	10.5 B						
	Regist	ar	OOT 0.9.20	107 900	- 15	Elegan.	Sec.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 28 **Physician** 11:25P ^M Levu 2007 Gail /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 4 STONEHENGE CIRCLE, UNIT #1 BALTIMORE Date of Birth (Month, Day, Year) 07/31/1943 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 K F MD 64 215-42-0277 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 No Funeral Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 4 STONEHENGE CIRCLE, UNIT #1 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: permit. Pages I and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other the any Injury or other trainmany Injury or other trainmany. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SAMUEL L. SHAPIRO & CO. **ENTRY CLERK** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVY MARTHA COHEN DAVID ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8710 EMGE ROAD, #2-B, BALTIMORE, MD PHYLLIS LEVY / SISTER 20b. Place of Disposition (Name of ANSHER), EMPRING O'THE Place) ALTZ CHAIM CONG. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 09/30/2007 BALTIMORE, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligense SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VOSCULAV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2/1 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 20 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: ို 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 1 🗌 Yes 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Ty

State

Registrar

32. Registrar's Signature

Year)

02

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Marcus Anthony Moore

2007 31476

	1- For State Registrar	Cert	tificate of	Death			Reg. No. 2007 31		
Physician/ ledical Examine	1. Decedent's Name (First, Midd	Anthony		Моо	re	2. Date of Dear Month September	Day Year er 16, 2007	1930 Nrs	
and seek.	4a. Facility Name (if not institute Interstate 95 at Route		41	o. City, Town, or Largo	Location of De	eath	4c. County of Prince G		
Funeral Director	5. Social Security Number 219-02-5066	6. Sex 7. Age (In yrs. la X M 2 F 24	st birthday) Yrs.	If Under 1 Year Months Day		140-	th(MM/DD/YYYY)	9. Birthplace (State or Foreign MD	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any mustic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 9237 Carter 11. Manital Status 1 Never Married 2 N	oward sville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No vorced If Yes, Give Year or Datas:	S. 13. Was	umbia 10f. Zip Code 2 Decedent of His, specify Cubai	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	White,	• A • - American Indian, Black, , etc. Black	
0036 within 72 hours after giene. Medical Examiner ompleted by			during mo	s Usual Occupa st of working life ent Fi	e. DO NOT use	retired)	Opera		
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. fant: If item 27 is marked other than is or other trannatic event, the Medical To Be Comple	Mark A. Moo	re			18.Mother's Na Miche	ame (First, Middle, ele Gunt	Maiden Surname) .er		
MD 21 d 2 should lth and Mer n 27 is ma aumatic ev	19a. Informant's Name/Relation Michele Moo					or Rural Route Nur Balti		n, State, Zip Code) Md 21214	
Baltimore, MC permit Pages I and 2 st Department of Health an Important: If item 27 injury or other trauma	20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other S	on 3 Removal from State	Place of Disposit crematory or other ilford	er place)		Date 10/1/07		City or Town, State	
Baltir permit. 1 Departme Importar injury or	21. Signature of Funeral Service	e License	22. Na Ma 43	me and Address rch F/ 00 Wab	s of Facility H West ash Av	: ve,Balti	more, N	Md 21215	
Physician	Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	Advitation la limitation		e mode of dying	, such as cardi	ac or respiratory an	rest, shock, or hea	Approximate Interval Between Onset and Death	
red Insit	Sequentially list conditions, if any, leading to immediate course. Find Unsarlying Course (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of c. Due to (or as a consequence of	_		: :::lanes:				
e execucian and rial - tra		c AMENDED							
8 in 18 C	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome of pregring Live birth 4 Pregnant at time of de Unknown	2 Fet	al death 3 ner (Specify)	Ectopic pre	egnancy	23d. Date of Month	delivery Day Year	
P.O. es that the igned by to be detache		itions contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		an 24b. V	bute to the cause of death? Probably 4 Unknown Were autopsy findings available	
tal Records, cian: The law require certificate has been sig ector, page 2 should b Be Completed		<u> </u>		_		auto perfo 1 ✓ Yes	ormed? d	orior to completion of cause of death? Yes 2 No	
Vital Rec ysician: The l his certificate l director, page	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Other N		Residence 6	Other: Scene	
Division of Vital Records, talor Attending Physician: The law requir rs after death al Director: After this certificate has been s led in by the funeral director, page 2 should be riffication: To Be Complete.	27 Monner of Dooth	nding Sep 16, 2007	28b. Time of Ir 1920 hrs		ury at Work? Yes 2 ✔ No	Operator of		ed hat collided with a	
Division o vithe Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 Suicide 6 Columbia	uld not be ermined 28e. Place of Injury - At ho (Specify) Interstate/E	Express			SB I-95 at MI	State) D-214, Largo, M		
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Certifi	29a. Centiler	Physician: To the best of my knowledg aminer: On the basis of examination a and manner stated.	ge, death occur nd/or investigati	on, in my opinic	n, death occur	, and due to the cau red at the time, date	and place, and d	lue to the cause(s)	
	29b. Signature and title of certif	with the second		- 1	.M.E.		September	ed (<i>Month, Day</i> , Year) - 17, 2007	
5		on who completed cause of death (Item ant Medical Examiner 111	^{23a)} Penn Stree	t, Baltimore	, MD 21201				
State Registra		32. Registrar's Signatu	ire	whi					
DriMin 17 Rev 1/2001	-	DOME	ORIGINA						

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a c hisha Matthe		State of Maryland / Department 1-For State Certification	ent of He ate of De			. No. 200	7 3147
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
Medical Exami	ner			atthews	Month September		2240 hrs
		4a. Facility Name (if not institution, give street and number) Maryland General Hospital		City, Town, or Location of E altimore	Death	4c. County of Deat	n
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 213-88-5958 1 M 2XF 30		Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. 12 0	(MM/DD/YYYY) 9. Bi Forei 9 76 Cc	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
. €			ltimo	re			1 X Yes 2 No
Maryland 28a-f show 1 at once.	ecto	10e. Street and Number	10	f. Zip Code	109	g. Citizen of What Cou	untry?
ith the Maryland 23a or 28a-f sho		1919 West North Ave		21217	=	U.S.A	•
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces?		ecedent of Hispanic Origin specify Cuban, Mexican, P		14. Race - Ame White, etc.	rican Indian, Black,
her dez ", or i		3 Widowed 4 Divorced If Yes 2 X No	1 Yes	a 2 X No specify:		Specify: B	lack:
hours, after "natural",	d by	15. Decedent's Education (Specify only highest grade completed) 16a. I	Decedent's U	Isual Occupation (Give kin of working life, DO NOT us	d of work done	16b. Kind of Business	/Industry
36 n 72 h nan "n jeal E	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	Ü	· ·	,	TT	Hognital
5-0036 led within 72 Hygiene. other than the Medical	Completed	12th grade na Adı	missi	ons Coordi	aiden Surname)	y Hospital	
21215 uld be files Mental Hy marked of	Be C	Calvin Matthews			er Harris	· ·	
MD 21215-0036 d 2 should be filed within 7 lith and Meintal Hyggene. In 27 is marked other than an matic event, the Medica	٩	1	_	dress (Street and Number			
ages I and 2 shount of Health and Nat. If item 27 is not other traumatic)	Rujiioi iii		Gelston Dri	Lve, Balt	20c. Location - City o	
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State cremator	tory or other p	place)		randalls	
Baltimo permit. Page Department o Important:	ŀ	4 Donation 5 Other Specify: King 21. Signet re of Funeral Service Licenses 1		ial Park S			
Dep Deri		Mara C. Sayant	4368	and Address of Facility The F/H West Wabash A	ve, Balti	more, Md	21215
Physician /Medical		23a. Fart I. Enter the disease, or complications to 1 caused the death. Do no failure. List only one cause on each line.	ot enter the m	node of dying, such as care	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer	7	mediate Cause (Final disease or condition resulting in death) a. ASthma Due to (or as a consequence of):					Death
Marin		Sequentially list conditions, b.			377		
	iner	if any, leading to immediate Due to (or as a consequence of):		12**			
77 × 12	Examiner	events resulting in death) Last Due to (or as a consequence of):					
executed in and il - transit	edical E	d. X UNPENDED AMSNOEPT 2020				<u> </u>	
60, ate be exe	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		<u>TT</u>		23d. Date of delive	ery
30x 6876 Jeath certificate e attending phy for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal d		pregnancy	Month	Day Year
Box 6876 e death certificat the attending phy ed for use as the	ysic	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other	(Specify)			
P.O. E that the d ned by the detached	by Phys	Part II. Other significant conditions contributing to death but not resulting	g in the unde	erlying cause given in Part			o the cause of death?
S, P uires th n signe	ed b						obably 4 Unknown
ord law rec has bee 2 shou	Completed				24a. Was a autops	y prior to	autopsy findings available completion of cause of
tal Rec		705 M(26.Place of Death (C	1 ✓ Yes 2		
Vital ysician his cert directo	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: Inpatient 2 VER/O	Outpatient 3	TOthor:		Residence 6 Oth	er:
fing Phy ding Phy After th funeral	H-1	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	y 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ion ttendii death tor: /	atio	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2 N	lo		
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, fa	actory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a Certifier	eath occurred	at the time, date and place	e, and due to the cause	e(s) and manner as sta	ated.
To the Ho within 24 F	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
	Ř	29a. Signature and title of certifier		29c. License number		29d. Date signed (M	
		Milyone Ine Voule		O.C.M.E.		September 23,	2007
8		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner		n Street, Baltimore,	MD 21201		
	tate	31. Date filed (Month, Day, Year)	An also				
Regis		UCI U 2 2001 Jacobs Jac	5346			DOME	
DHMH 17 Rev 1/2	001	₫R	RIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 26, 2007 Physician Maroney Mary 3:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2/2 F 220-38-8010 88 West Virginia Director July 17,1919 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dunda 1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 1944 Guyway 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No δ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Saleslady **Epsteins** Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Bolyard Nellie Stieringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Maroney son 1944 Guyway, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MAryland 29, 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EPOTIC CARDIOVASCELAR /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be execut burial-tran Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an performed 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 2 100 Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, filled in by the completely within 2 the

State

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

lame and address of person who completed cause of death (Item 23a) (Type, Print)

Year

OCT 0 2 2007

32/Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 31479 Certificate of Death 3. Time of Death 2. Date of Death Month Year **Physician** 1244 AM 200-/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner tospital Baltmore Himore 6 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Days Hours Min Director 10a. State 10c. City, Torra or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No 2. Himpre Funeral Director 10g. Citizen of What Country? or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Armed Forces? 11. Marital Status Black, White, etc. 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural"; other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. ary (0-12) College (1-4or 5+) Name (First, Middle, Last Be n and Mental is marked o 20 27 20a. Method of Disposition Pages 1 Department of Important: If its any Injury or o once. 1 ☐Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or rear failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emorrhagi Physician day /Medical Due to (or as a consequence of); **Examiner** SSEMMINITED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21110 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy cate has performe certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 Tyes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 7005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Mohth

Year)

0 2

32. Registrar's Signature

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygien 2007 3 | 4 8 | 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sept 29, Elizabeth McFadden 2007 6:00 A M Mudd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8501 Mimosa Ave Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State of Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 F Months Director 578 56 0022 Feb 2. 1943 Washington the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23a or 28e-f show traumatic event, the Madical Examiner must be notilled at 1 Yes 2 No Directo Maryland Prince George Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 8501 Mimosa Ave 20735 Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. 1 ☐ Yes 2 No If Yes, Give X 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Com Real Estate Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental Hi item 27 is marked oth Be Hugh Joseph McFadden Marian Ennen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William J. MUdd (Son) 8501 Mimosa Ave, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ott 1 Burial 2 Cremation 3 Removal from State Oct 1, 2007 Lee Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROGRESSIVE, METASTATIC HEAD & NECK CANCER **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy The law requires that the death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown I signed by till Id be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 2 \(\text{No} \) 1 Yes To the Hospitel or Attending Physicien: within 24 hours efter death.

To the Funeral Director; After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59942 10/01/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 WOODYARD ROAD, SHITEZOI, CLINTON, MD 20735 DEEPNARAYAN TIWARRI, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MABERY optember, 30, 200 7 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARBOR IMORE H0261141 BALT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ Months Days Hours 219-10-9355 Oct 31,1927 North Carolina Director Usual Residence of Decedent r 28a-f show notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Director Brooklyn Md. Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 U.S.A. 21225 206 East Jeffrey Street by Funeral ral", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White 3 ₩idowed 4 Divorced Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked other traumatic ev Katherine ဥ <u>Charles</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 East Jeffrey Street Baltimore, Md. 21225 Betty Schmier, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State /04/2007 Baltimore, Md. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Sirvin Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Balto. Md. 21225 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner PER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha performe 2 KV No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To. 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending s after death.

al Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 🛛 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. and manner stated.

ASAM DED AYAT, 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) September, 30, 2007 Type, Print)
HANOVER STr., BALTIMORE, MD, 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) OCT 0 2 2007

320 legistrar's Signature

parte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Morgan /Medical 4a. Facility Name (If not institution, give street and num 4c. County of Death 4b. City. Town, or Location of Death Examiner Bultimore Bultimore Rehabilitation Extended Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Jan. 27 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Year) 1919 17€ M 2□ F Months Days Hours 88 Maryland Director 219-18-5056 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at Y Yes 2 No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 437 Random Road 21229 United States items 23a Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hyglene.
sint: if fleam 27 is marked other than "natural", or items 23.
sury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? t⊊Pyes 2 □ No If¥es, Give Korean Year or Dates: War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Military Servicemember 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William W. Morgan Annie C. Krausz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda J. DiVincenzo/Sister 437 Random Road, Baltimore, MD 21229 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ite
any Injury or ot
once. MD veterans Cemetery X Burial 2 Cremation 3 Removal from State 10-2-2007 Crownsville, MD 4 □ Donation 5 □ Other (Specify) @ Crownsville Ambrose Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia im Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 1 Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) Injury To the nosposite death.
within 24 hours after death.
To the Funeral Director: After the funeral by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

John S. Lah, M.D. 3900 Lich

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) OCT 02 2007

Raven Boolevard, Beltimore, maryland 21218 32 Registrar's Signature

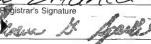
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🎧 🧻 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician HELEN Day C. MINCE \$EPTEMBER 25,2007 5:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HERITAGE CENTER DUNDALK BALTIMORE 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 8 - 8 - 1907 9. Birthplace (State or Foreign **Funeral** 1□ M 2□F Months Days Hours Min 216-18-6429 100 MÄRYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD BALTIMORE Director ROSEDALE 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be r 1226 KENDRICK ROAD 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 ☐ Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Be **GEORGE** DAVIS LUCY (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THELMA ILGENFRITZ/DAUGHTER 1226 KENDRICK RD Department of Health Important: If item 27 any injury or other tr ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) SACRED HEART MARY 9-28-07 DUNDALK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 14 BETES The law requires that the death certificate be executed Box 68760, Physician/Medical PERTENSION IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 211110 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical Locatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

0CT 0 2 2007



Place Dundalle MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [7] 31485 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MAR SHALL ELIZABETH SEPTEMBER 2007/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSEDALE FRANKLIN WOODS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4-4-1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MARYLAND 72 1 □ M 2√2√x Yrs 214-34-2605 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No RASPEBURG Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21206 U.S.A. 5432 BUCKNELL ROAD or Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian a filed within 72 hours after di J. Hygiene. other than "natural", or Item Black. White, etc. ☐ Yes 2 XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 12 should be filed v h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES NELSON MARIE (STOCKMAN) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 is VERNON M. MARSHALL/HUSBAND 5432 BUCKNELL RD 21206 BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GARDENS OF FAITH C 10-1-07 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC HEART Physician /Medical Due to (or as a consequence of) **Examiner** HTN Sequentially list conditions if any, leading to infradiate cause. Enter Underlying Cause (Disease or injury Directo for as a nonsequence of Examiner CAD certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ pe FIBRILLATION 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown leted CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Comply certificate has autopsy perforr 1 ☐ Yes 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal pletely (Check only one) and manner stated To the the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 D4000

Registrar

FRANKLIN SQUARE

DR. BALTIMORE, MD

arshall

PARSHALL

and address of person who completed cause of death (Item 23a) (Type, Print)

105

Division or Vital Records, P.O. Box 68760,

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Certification: To Be Completed by Physician/Medical Examiner	Immediate disease or resulting in Sequential I any lead cause. En Cause (District that initiate resulting in the 1 Ye 23b. Was constant in the 1 Ye 27. Was carexamin 1 Ye 27. Manner 1 ZNa 2 Ac 3 Su	ise referred to medical er? s 2 No rof Death tural 5 Pendli cident invest icide middle err rof Death tural 5 Pendli cident icide middle err rof Death tural 5 Certifyl err	al H	Due to Due to	each line. (or as a company of the	conseque conseq	cy death 5 ting in the under the control of the con	□Ectopic pregnanc □ Other (specify) □ nderlying cause given to 3□ DOA Other M 1□ 28c. Inju	ey ven in Part I. 26. Place of her: 4 Nurs inv at ink? Yes 2 Nurs ime, date and	of Death (sing Homes	23e. Did to 1 24a. Was autor performed autor for the control of th	obbacco u Yes 25 an Osy rmed? 22/No one) dence 6 now injury cause(s)	23d. Date of Month use contribute 24b. Were prior death 1 1 Y 6 Other (S) y occurred	deliver	Interval Betwonset and Duset	To Be Completed by Physician/Medical Examiner	Immediate disease or resulting in Sequential I any lead cause. En Cause. En	ise referred to medical er? s 2 No rof Death tural 5 Pendli cident invest icide middle err rof Death tural 5 Pendli cident icide middle err rof Death tural 5 Certifyl err	al H Ing igation into be mined in properties of the mined in the mine	Due to Due to	each line. (or as a complete of the complete	conseque conseque conseque pregnanc Fetal d me of dea not resulti 2	cy death 3 at a single farm, straining in the unit on and/or invited the control of the control	Dectopic pregnanc Other (specify) Int 3 DOA Other M 28c. Inju M 1 ceet, factory, office th occurred at the tovestigation, in my 29c. Licen:	26. Place of her: 26. Place of her: 4 Nursing Attention opinion, death and opinion, death se number 3 / 8 6 3	of Death (sing Home) 28 0 28	23e. Did to the dat the time,	obacco u Yes 2E an ssy rmed? 22No one) dence 6 now injury cause(s) date and	23d. Date of Month ase contribute No 3 24b. Were prior death 1 Y 6 Other (S) y occurred d Number or and manner d place, and of the signed (Month)	deliver e to the proba a autopo to com h? r Rural r as sta due to	Interval Betwonset and Every Conset and

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year GERTRUDE KAMEN MILLS SEPTEMBER 30, 2007 /Medical 7:30 A. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7220 GREENBANK ROAD MIDDLE RIVER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🛛 F Director 132-05-2609 3/24/1920 NEW YORK Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 BRETT COURT APT. 207 21221 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify: ρ 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) COMMERCIAL DRYING 12TH GRADE DRYING Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ WILLIAM A. MEYLER MARY ROSE McGUINNESS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAN KAMEN/SON 7220 GREENBANK ROAD BALTIMORE, MD 21220 Place of Disposition (Name of cemetery, crematory or other place)
 LONG_ISLAND_NATL 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/4/2007 PINELAWN, L.I. 21. Signature of Funeral Service Lice 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a confequence of): /Medical Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown ate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 2 No 24a, Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 5 ☐ Residence 6 SON S RESIDENCE Other: 4 Nursing Home 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? spital or Attending P nours after death. neral Director: After t y filled in by the funera After t 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Than POOD, MD, FACE D 57088 OCTOBER 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\mathcal{O}_{i'}$ Baltimore, Hau # 701 MD 2/20) ST. au 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

0 2 2007

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend #2,PI line c, perMD, 68/2, 10/2/07 The Registrar

Registrar

Reg. No. Reg. No.2 2. Date of Death Month SEPT 1. Decedent's Name (First, Middle, Last) **Physician** 28,2067 8:30PM III EDDIE MCCULLOUGH /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 601 WYANOKE AVE. APT.511 BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** AUG. 14, 1967 Days Hours Min 1□M 2□F 40 216 84 3317 Director MD_ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√2Yes 2□No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA APT.511 21218 **601 WYANOKE AVE** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 □ Yes 2 Ϊ No Specify: BLACK Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SELF EMPLOYED CHEF yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCOTT MABLE EDDIE MCCULLOUGH JR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EMLEY AVE. BALTO, MD. 21213 MABLE MCCULLOUGH (mother) 3807 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State SEPT.26,2007 BALTO,MD. TRINITY CEM. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that cau, of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ceresovander **Physician** as Yonsequence of): /Medical Due to (or as Examiner Jue to (or as a nonsirolamon of) On Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chronic Kidney Disease The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) attending physician HIV Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4 Unknown 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3∏ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident atter death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital c within 24 hours at To the Funeral Di

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

K Bennett

Johns Hopking Mospital 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

600 North Wale Greet Beltima e Margiard 21287

29c. License number

000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 22,2007 Villmar Stuart McEvoy 10:48 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

> Towson If Under 1 Year | If Under 24 Hrs.

Hours

Days

Months

Physician /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mertal Hyglene. ant: If Item 27 Is anxied other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at Directo Completed by Funeral Baltimore, Maryland 21215-0036 Be ဥ permit. Pages 1 Department of H Important: If Ite any injury or ot Physician /Medical

Examiner

attending physician and for use as the burial-transi certificate has lirector, page 2 s or Attending Physician; director,

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner Medical Certification: To Be 29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

10+1 Registrar

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Belmont Forest Court 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Executive Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip McEvoy, Charles Sr. Ruth Marburger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) Wife 210 Belmont Forest Court #106 Timonium, Maryland McEvoy Barbara 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Memorial Gardens 9-27-2007 Marriottsville, Maryland 21. Sinneture of Finn al Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive mouths disease or condition resulting in death) Due to (or as a consequence of): (OPD Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuluence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nospec 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 TYes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

00051926

29c. License number

🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) September 23, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 YNo

Maryland

8. Date of Birth (Month, Day, Year) Sept.19,1928

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- Ni Charles St Baltmane MD 21204 . Gorden MO 6565 31. Date filed (Month, Day, Year)

OCT 0 2 2007

(Check only one)

Gilchrist Center

10b. County

6. Sex

Baltimore

1**X** M 2□ F

7, Age (In yrs. last birthday)

10c. City, Town or Location

Timonium

79

Social Security Number

218-22-6405

10a. State

Maryland

Usual Residence of Decedent

32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 16b per fb 9872 10-2-07 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ton MedCt Bluma 5. Social Security Number Birthplace (State or Foreign Country)
 MD . Age (In yrs. last birthday, If Under 24 Hrs 8. Date of Birth (Month, Day, May 10, Funeral Months Days 1924 1 XI M 2 □ F 83 216 -14-2244 May Director Usual Residence of Decedent 10a. State death with the Marylan 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Anne Arundel Annapolis Examiner must be notified 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21401 USA 2124 Renard Court Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No Yevy If Yes, Give Year or Dates: WII 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify. Specify: 3 ₩ Widowed 4 Divorced Completed Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturury or other traumattc event, the Medical. 16b. Kind of Business/Industry
SeaFaring 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boat Capt. / Mechanic Sea Faring 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Smith Marvin R. Marshall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Maple Avenue, Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type. Print) Deborah A. Marshall 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cemetery 10/2/2007 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee Victor P. 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for Month Year Day P.O. signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2 ☐ No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performe certificate 25 or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) inby 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 08 Landmark Dr. Glen Burnie MD M.D 31. Date filed (Month, Day, Year) 32. Registar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2017 hro dove 25,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RUXTON PIKESVILLE NURSING HOME PIKESVILLE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/13/1924 **Funeral** MD 219-12-7142 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 HAMLET HILL ROAD, #1413 21210 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No WWII I Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married WHITE 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEN'S CLOTHING MANUFACTURER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MANKO NEWHOFF, SR. RUTH **THEODORE** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If them 27 Is a any injury or other traun 111 HAMLET HILL ROAD, #1413, BALTIMORE, MD DOROTHY B. NEWHOFF / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State OHEB SHALOM CONG. 09/30/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Inset and Death Immediate Cause (Final **Physician** Dispuse disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Yea in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 210 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 26,2007 037573 led cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Zpell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 2 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28 Month Catherine R. Ottey 53 PM **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Square Hospital FOSCICLE

If Under 1 Year | If Under 24 Hrs. Frantlin Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7 – 4 – 1 9 2 1 Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 215-16-0881 1 ☐ M 2 🔀 F 86 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 VNo Baltimore MD Funeral Director death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8810 Walther Blvd. #3219 USA 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify:White Completed by 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. USF&G College (1-4or 5+) N/A Clerk 18. Mother's Name (First, Middle, Maiden Surname)
Mary A. Cassidy and 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be George A. Davis ဥ 1 and 2 should Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1250 Bonaire Rd. Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type. Print) Francis Ottey- Son Health 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).
Gardens of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' Department of Important: If It any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 10-3-2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name anti-varisof Formeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 ☐ Other (specify) o 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury

"forth Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director: / 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065094 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 Binh 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 02

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Atherio

	For State Registrar		artment of Health and rtificate of Death	Reg. No	2007 31493
Physician /Medical	1. Decedent's Name (First, Middle, La	ORANGE		2. Date of Death Month $Q / 30$	7 87 Year Grant Gr
Examiner	4a. Facility Name (If not institution, given 5910 Simmons	1s avenue	4b. City, Town, or Location of Dea Baltimor If Under 1 Year If Under 24 Hrs	re	County of Death
Funeral Director		Sex 7. Age (In yrs. last birthday) 1 M 2 F 84 Yrs.	Months Days Hours Mir		9. Birthplace (State or Foreign Country)
Maryland -f show fied at	10a. State 10b. County	10c. City, Jone or Lo	himore		10d. Inside City Limits 1 N res 2 □ No
with the Mar 3a or 28a-f st at be notified	10e. Street and Number 5910 Simmone	1	10f. Zip Code	10g. Cit	izen of What Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland if et and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 D No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
filed within 72 hou Hygiene. wher than "natura ent, the Medical E		College (1-4or 5+)	dent's Usual Occupation wind of work done during most of we bo woruse retired Kepaiman	S	he Shep
2 should be fill and Mental H is marked ott aumatic even	John C. Ora	nge	Doro	ame (First, Middle, Maider 1 Mon Co	1e
Pages 1 and 2 sh ent of Health and nt: if item 27 is m iry or other traum	19a. Informant's Name/Relationship Dora Parson 20a. Method of Disposition 1	s Claughter 230	ng Address (Street and Number or F Desired Part of Pa	intSt.Bah	or Town, State, Zip Code) Timere Malallo pocation - City or Town, State
permit. Pages 1 Department of L Important: If ite any injury or ot	4 □ Donation 5 □ Other (Spec.	fy) Druid 1	KIGGE 101 Want of Address of action	5 107 Da	HIMORY IND SVCS- HIMORY MOLALARY
ificate be executed as the buriat-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	pplications that caused the death. Do not enforce cause on each line. a. GASTRIC Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):	ter the mode of dying, such as cardi		Approximate Interval Between Onset and Death
hat the death certificated by the attending pheterched for use as the Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that signed by id be deta	at it. Other significant conditions	contributing to death but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
n: The faw requirected ficate has been str, page 2 should Completed				24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
hysiciar his certif il directo	examiner?	Hospital: 1 Inpatient 2 ER/Outpatien	Other:	eath (Check only one) Home 5 Residence	6 □Other (Specify)
l or Attending P after death. Director: After t d in by the funera ertification:	27. Manner of Death The Natural 5 Pending investigation 3 Suicide 4 Homicide determined	De 28e Place of injury - At home farm st	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju 28f. Location (Street a City or Town, State	nd Number or Rural Route Number,
the Hospita in 24 hours the Funeral ipletely filled		hysician: To the best of my knowledge, deat miner: On the basis of examination and/or ir and manner stated.			
To th within To th comp	29b. Signature and title of certifier	2	D 29 c 7		ate signed (Month, Day, Year) 2 - 2 - 3 -
State	30. Name and address of person who RANANDA WAL IS 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Type, It ~ A ~ & Z ~ N ~ E (Print) UTAW ST # 303	BACTIM	ONE MD 2/20/

DHMH 17 Rev 1/2001

ORIGINAL

07-07594 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Perrera 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last Physician/ September 27, 2007 1223 hrs **Medical Examiner** 010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 59 Caraway Road Reisterstown Baltimore 6 2 2 2 If Under 24Hrs. Date of Birth (MM/DD/YYYY) g. Birthplace (State of 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 6. Sex **Funeral** Foreign Months Days Hours Min. Country) /// Director М 2 Usual Residence of Deceder 10d. Inside City Limits 10a. State Ioc. City, Town or Location 10b. County Rny 1 Yes 2 No 28a-f show It more death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status . Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes 2 Give Yea 2 X No specify. Specify: **V** Divorced 3 Widowed ٥ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 18.Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) ۵ 2605 212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 Burial 2 Cremation 3 crematory or other place) Removal from State Donation 5 Other Specify PALTIMORE, MD 21234 21. Signature of Funeral Service Licensee plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ase, or col art I. Enter the di Physician Between Onset and failure. List only one cause on each line M-dica Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed AMENDED #23a,27,perME,g873, 11/6/07 TT 4c.perME,g872, 10/16/07 TT Physician/Medical X UNPENDED After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o Yes 2 No 3 Probably 4 ✔ Unknown à Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' Yes 2 1 🗸 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be examiner? Hospital: Other4 Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 FR/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No Pendina Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) To the Hospital or within 24 hours at To the Funeral D Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 28, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER JOYCE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL BALTIMORE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 171/F Months Days Hours Director 229-44-2821 March 12 1937 Virginia Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 → No Md. Anne Arundel Co. Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e ns 23a c must be 106 Haile Ave. Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a rry or other traumatic event, the Medical Examiner must Funeral 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔁 No 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Hill 2 Josephine Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tronce. Elvin Payne, husband 106 Haile Ave. Baltimore, Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Park 10/3/2007 Glen Burnie, Md. 4 □ Donation 5 □ Other (Specify) 21. Signatu A Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SMALL HOWEL and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Month Year 5 ☐ Other (specify) ed by the a detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?/ /es 2 No certificate I 1∐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of I or Attending Patter death. 28c. Injury at Work? After 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined fo tin.
within 24 hour.
*he Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

be executed Box 68760, P.O. or Vital Records, Division

the Maryland

with 1

Baltimore, Maryland 21215-0036

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BEBU 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

PHYSICIAN

29c. License number

000

29d. Date signed (Month, Day, Year) SEPTEMBER 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 2 2007

HANO VER 32 Registrar's Signature

BALTIMORE, MD 21225 STREET,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Julia Estella Proctor September 2007 4:55 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford | Months | Days | Hours | Min. | Month, Day, Year | Months | October 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Maryland 1 M 2 TyF 220-14-3672 Months 81 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No X Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2106 White House Road 21015 United States of America or No14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Worker Printing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amos Albert Davis Grace Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Terry Proctor 20a. Method of Disposition 2106 White House Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (Son) 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Memorial Pk 10/02/07 Sykesville, Maryland 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee M00333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1-X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be

The law requires that the death certificate be executed the attending physician P.O. Box 68760 certificate has been signed by rector, page 2 should be detach にいる アゥゥニロア サ Division or Vital Records,

MECOASA

After this

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

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Certification;

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31. Date filed (Month, Day, Year)

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any Injury or other traumatic event once.

Physician /Medical Examiner

Pages 1 and 2 should I nent of Health and Men

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State Registrar

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

2007

North 32. Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

Ricky Ray 07-07535 UNK

Me

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2007 31498

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Fund	rai	5	. Social Security N	Number 6. Se	7. Ag	e (In yrs. last bir	thday)	If Under 1 Year Months Day		Min.	3. Date of Birth			
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TO Pages ent of	발탕	1	4 Donation	5 Other Speci	fy:	King	Memo	orial	Park	19/2	8/0/	Randa	ILISC	own, Md
Baltimore, permit. Pages 1 ar Department of He	Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		24 Signature of F	Funeral Service Lic	ensee		² M a	are and Address 300 Wa	TH WE	est.	- Dal+	imore	s. Md	21215
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Division of Vital Records, P.O. Box 68760, ro the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death To the Funeral Director:			Certifying Ph	niner:On the basis o	f examination ar	nd/or investi	gation, in my or	inion, deat	h occurred	at the time, da			
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07-07411 Robert Rutledge

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2007 31499

		1- For State Registrar	Certific	ate of Death	ia wierkar i		g. No.	
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Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bi			_	(MM/DD/YYYY) 9. Bi Forei	
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Maryland , 28a-f show any'	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?
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ath with the Maryland tems 23a or 28a-f sho	Funeral	11. Marital Status 12 1X Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba			14. Race - Ame White, etc.	rican Indian, Black,
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5-0036 led within 72 hou Hygiene. other than "nat th. Medical Exa	Completed		College (1-4 or 5+)			ilicu)	C = V =	an la
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21215-0036 Suld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be	John Rutledge				anna Ja		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ts marked other than "natural", or items 23a or 28a-f she after event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type: Georgeanna Pete:	Print) 1!	Bb. Mailing Address (Str 1810 North	eet and Number or	Rural Route Numb	per, City or Town, Stat	e, Zip Code)
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Baltin permit. Pe Departmen Importan injury or	1	4 Ponation 5 Other Specify: 21 Significant of Funeral Service Licensee		22 Name and Addre	ss of Facility			
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Physician /Medical		23a. Part I. Enter the disease, or complicat failure. List only one cause on each I	ne.	not enter the mode of dyin	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
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lsit sd	Exan	events resulting in death) Last	to (or as a consequence of):					
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760, cate be physicia	Medical		3c. If yes, outcome of pregnanc	<i>y</i>			23d. Date of delive	ry
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Box 68760 to death certificate by the attending physicate for use as the bu	ysic	1 Yes 2 No 9 Unknown		5 Other (Specify)				
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should lead in by the funeral director, page 2 should lead in by the funeral director, page 2 should lead in by the funeral director, page 2 should lead the funeral director, page 2 should lead the funeral director bage 3 should lead	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office	building, etc.		treet and Number or F ate) Parkwood Avenue, I	Rural Route Number, City
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 4 Contifuing Physicians	(Specify) Alley To the best of my knowledge, de	eath occurred at the time.	date and place, and	1		
To the I- within 24 To the E- complete	Medical	one) 2 Medical Examiner; 2h	the basis of examination and/or manner stated.					
	Me	29b. Signature and title of certifier			nse number		29d. Date signed (M	
7					C.M.E.		September 24,	2007
OCME		30. Name and address of person who com Mary G. Ripple MD. Deput	pleted cause of death (Item 23a) / Chief Medical Examine		et, Baltimore. N	MD 21201		
_	ate	31. Date filed (Month, Day Year)	32. Régistrar's Signature		,			
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Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

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ause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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